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DOCTORAL THESIS

Developing confidence in negotiating the multiple influences in understanding sex and sexuality in therapeutic practice
an interpretative phenomenological analysis of counselling psychologists' perspectives

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Developing confidence in negotiating the multiple influences in understanding sex and sexuality in therapeutic practice: An Interpretative Phenomenological Analysis of Counselling Psychologists' perspectives.

By

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A thesis submitted in partial fulfilment of the requirements for the degree of PsychD in Counselling Psychology

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Abstract

Understanding sex and sexuality, particularly in the context of therapeutic work has been consistently identified as problematic. This qualitative study focused on the accounts of 8 counselling psychologists' understanding and experiences of working with sex and sexuality. An interpretative phenomenological analysis was conducted and three master themes were identified. These highlighted how participants negotiated firstly, the influences of circulating cultural norms, in the past and present, secondly, the diverse presentations of sexuality and thirdly, the challenges of working therapeutically in relation to sex and sexuality. These negotiations and challenges were presented in their appraisal of their own personal lives; and in their training and professional experiences in client work. Participants' developing confidence as practitioners seemed to be related to their capacity to re-evaluate their understandings of sexuality both personally and in relation to their therapeutic work. Overall, this research makes visible how a reflexive approach can inform counselling psychologists' understanding that sex and sexuality are not static concepts and require continual questioning and revision.

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CHAPTER 1 INTRODUCTION

1.1 Overview

The introduction to this research will firstly, identify the complex, diverse definitions and explanations for how 'sex' and 'sexuality' are understood in the contemporary psychological and counselling field. Some of the ways in which 'sexuality' and 'gender' are linked to understanding 'sex' will also be explored. Secondly, this chapter will aim to clarify what a sexual issue is, in relation to therapeutic work. Thirdly, it will address what counselling psychology is and how understandings of sex and sexuality are relevant to the practice of counselling psychology (CoP). Finally, this chapter will also consider some of the extant literature that provides a rationale for why sex and sexuality are important topics for counselling psychologists (CoPs).

1.2 Defining sex and sexuality in the context of this proposed study

The definition of 'sex' which first emerged in the 16th century, referred to the differences between male and female biological features (Weeks, 1986), a meaning that is still recognised today (Fausto-Sterling, 2000; 2005; Denman, 2004; World Health Organisation, 2006). 'Sex', as it is now also known in contemporary culture, relates to the act of 'having sex', a meaning which first emerged in the 19th Century (Weeks, 1986). This act of having sex, or engaging in 'sexual activities' (World Health Organisation, 2006), cover a wide range of possibilities as this chapter and the next will show. Weeks (2010) argues that 'sex' both historically and presently, is largely regarded as heterosexual penile-vaginal intercourse (PVI). PVI has also been associated with reproduction rather than pleasure, which is independent of procreation (Holland, Ramazanoglu, Sharpe and Thomson, 2004). Forms of 'sex' other than PVI, have also been considered in past and recent research surveys (Kinsey, Pomeroy & Martin, 1948; Kinsey, Pomeroy, Martin & Gebhard, 1953; Mercer, Tanton & Prah et al, 2013; Sanders & Reinisch, 1999; Pitts & Rahman, 2001; Randall & Byers, 2003). The terminology utilised by these researchers, to define 'sex' other

than PVI, has been found to be limited. For example, Kinsey et al's (1948) use of 'petting' appears to vaguely refer to non-PVI sex. Some mainstream surveys have attempted to compare definitions of sex, between heterosexuals and non-heterosexuals, which has been problematic for two reasons. Firstly, the small sample sizes of non-heterosexuals compared to heterosexuals and secondly, the limited range of sexual activities included in the surveys. For example, Richters & Song's (1999) study contains just 24 non-heterosexuals compared to 446 heterosexuals.

More recent studies such as Horowitz & Spicer (2013) and Hill, Rahman, Bright & Sanders (2010), attempt to counter the heterosexual bias of these research surveys by adapting these questionnaires to include sexual activities that gay men and lesbians may engage in, including anal and oral sex and the use of sex toys. These studies confirm that non-heterosexuals more commonly recognise that sex is not just PVI. The widening of sexual possibilities in these studies, still seem to be limited by these researchers' sexual assumptions. To counter the aforementioned sexual assumptions, Attwood, Bale & Barker (2012) propose that a broader range of sexual activities, across the sexuality spectrum, could be applied to sexual understanding and definitions. These include: solo sex; sex with one, two or multiple partners; 'sex' where people are physically present in the room, or not (such as phone or internet sex); to 'kinky' behaviour, such as sexual role play or sadomasochistic activity for sexual pleasure. These examples suggest that the diversity of activities that constitute 'sex' can reflect a wide range of behaviours and perceptions. These differing sexual meanings are important for CoPs to acknowledge, as these may not be easily understood by CoPs within the context of therapeutic practice, a situation that may present problems for the therapeutic relationship.

In recognition of the diversity of possible sexual meanings that may arise in therapeutic work and CoP, the working definition adopted by this study, refers to Stanley's (1995) notion of 'sex' as related to *'sexual feelings, thoughts, behaviour and the discussion thereof'* (Stanley, 1995,

p.28). This definition is open enough to account for experiences that manifest, in therapy, through the discussion of clients' sexual feelings and experiences that occur outside the therapeutic context; and can accommodate the development of sexual feelings by the client and/or CoP towards each other, within the therapeutic relationship, a process commonly referred to in the psychodynamic literature as transference and countertransference (Lemma, 2003).

The diversity of the definitions of sex support O'Donovan and Butler's (2010) argument that what may be considered as a sexual feeling, desire or behaviour, are highly variable, across different time periods, peoples, contexts and cultures. These sexual understandings are also associated with ideas about the 'normality/abnormality' of appropriate sexual conduct according to social gender roles and thus, how people express themselves as 'sexual' beings and embody a 'sexuality':

'Sexuality is related to emotions, roles and ideas and shaped by diverse experiences throughout the lifespan and encompasses far more than the gender of sexual partners chosen or the type of sexual acts engaged in. Our sexual selves are shaped by many of the same contexts and events that shape the kind of individuals we become' (O'Donovan & Butler, 2010, pp.7).

This definition of sexuality goes beyond references to sexual activities, sexual orientation and/or sexual identities (World Health Organisation, 2006). The broader meaning of 'sexuality' as opposed to sex, highlights how sexuality influences the understanding of sex. The diverse, changing definitions over time, for 'sex' and 'sexuality' make understanding these sexual concepts problematic as there is no one fixed definition.

The differing meanings of sex and sexuality, cited above, can also be explained by the role of the sociocultural context, an argument which is developed by Plummer (1995; 2003) and Simon and Gagnon (2003). Plummer (1995) argues that individuals' ongoing sexual experiences influence the stories people tell about how they understand 'sex' and therefore, how they construct their own identity and sense of their self as a sexual being, i.e. as having a sexuality (Plummer, 1995). This highlights Plummer's (2003) subsequent argument that sexual meanings are the product of individuals' negotiation of social relationships and legislative structures that impact their intimate worlds, a concept he defines as 'intimate citizenship'. The individual intimate experiences of the self, via feelings, the body and sexual identity, are 'never entirely solitary' (Plummer, 2003, pp. 13) as they cannot be separated from the social world each person inhabits.

This concept of sexuality is related to Simon and Gagnon's (2003) 'sexual script' theory. This proposes that individuals negotiate their interaction (including conflicts) between personal sexual feelings, thoughts, desires and the perceived appropriate sexual conduct, through the processing of sexual scripts. These sexual scripts are akin to 'schemas', clusters of information drawn from their social world that individuals carry about how to behave in various interpersonal situations. A person's understanding of their sexuality therefore influences their sexual understanding and conduct, both in relation to their self and other people (expanded in section 2.4). These theories suggest that it is difficult to separate the understanding of sex and sexuality from the influences of the social context.

Furthermore, rules of sexual conduct, Jackson and Scott (2010) have noted, are affected by how wider sexual cultural norms and moral ideas influence how sexual attitudes are formed over time. This is evident in the altered attitudes to the legitimacy of sex before marriage, contraception and abortion (Nye, 1999); and the increasingly wider acceptance of homosexuality as demonstrated by the recent legalisation in the UK of same sex marriage in 2013 (Miller,

2013). However, despite greater openness to sexual attitudes, over time, various authors (Greer, 1971; Eichenbaum and Orbach, 1982; Wolf, 1991), amongst others, have highlighted that attitudes towards women's sexuality are implicitly and explicitly regarded as less important than that of men, due to the male dominated patriarchal structure of society. These attitudes, in subtle and not so subtle ways, still persist today in the form of sexism, through varying forms of discrimination due to the assumption that women are less powerful than men (Bates, 2014). These examples illustrate that the mutability of sexual behaviours and how social relations are conducted (and, thus, what is referred to as 'sex'), is reflected in the socio-political context. These factors have implications for how counselling psychologists understand sex and sexuality and the consequent impact on their professional practice, which is of interest to this proposed research.

The above references to sexism, highlight that the concept of 'gender' also contributes to how 'sex' and 'sexuality' are understood. As a social construct, gender attributes social roles according to reported biological distinctions between male and female (Bradley, 2013), which can also contribute to what may or may not be considered 'appropriate' sexual behaviour. Fausto-Sterling (1993; 2000; 2005) argues that biological sex differences are not straightforward, as anatomy, chromosomes and hormones do not necessarily give a clear definition of an individual's biological sex. This is illustrated by the examples of intersex (those with biological aspects of both male and female) and transgender individuals' crossing of accepted gender boundaries (Fausto-Sterling, 1993; 2000). Fausto-Sterling (2005) argues that these examples of challenges to accepted gender roles, illustrates that how sex differences are defined are also the product of sociocultural influences. Bradley (2013) argues that gender roles define how girls/women and boys/men believe they should act. These behaviours also seem to permeate several areas of social and personal life, and, it could be inferred, can also extend to what a person thinks sexual activity is, or should be.

Debates about what sex, gender and sexuality are and how to approach working with sex and sexuality therapeutically, have also been influenced by biological, psychological and sociological perspectives. Freud (1856-1939) initially dominated the psychological perspective and is well known for his (now widely disputed) theories about how sex is at the root of all psychological problems. From a biological perspective, researchers such as Kinsey et al (1948), Kinsey et al (1953) and Masters and Johnson (1966; 1970; 1979), amongst others, have contributed to the knowledge about sexual behaviour and its physiological mechanisms and function. More recently, symbolic interactionist theories (Plummer, 1995; 2003; Simon and Gagnon, 2003) have acknowledged, the impact of the sociocultural context on meanings of sex, gender and sexuality. Poststructuralist theorists, such as Foucault (1981; 1986; 1988), Butler (1990) and Weeks (2010) go further, by challenging the dominant, fixed biological influence in defining sexuality and gender and argue that these concepts cannot be labelled and are socially constructed performances that do not define individuals. How these different perspectives affect the understanding of sex and sexuality, in relation to CoP practice, is explored further in Chapter 2.

This brief exploration of sexuality and gender, in relation to 'sex', emphasises that 'sex' is not a straightforward concept and is therefore problematic to define for both the wider public as well as CoPs. It has many changing meanings that are dependent on the social, cultural and political contexts that individuals inhabit and cannot be assumed to be one thing. In relation to psychological counselling/psychotherapeutic work (forthwith referred to as therapy or therapeutic work; see 1.4 for definition of therapeutic work in relation to CoP), this poses issues as to how CoPs engage in a dialogue about sexual meanings, both for themselves and in relation to their clients.

1.3 What is a sexual 'issue' within therapeutic work?

Similarly to 'sex' and 'sexuality', the common usage of sexual 'issues', within the therapeutic context, is also difficult to define. 'Issues' can refer to a 'neutral' term meaning a 'subject' or 'topic' of conversation, but could also mean, a 'difficulty' or 'problem' (oxforddictionaries.com, n.d.). The range of sexual topics that emerge in therapy, can make the word 'issue' complicated, as it may refer to 'sexual abuse; 'rape'; 'sexual addiction' 'sexual dysfunction'; 'sexual problems'; 'sexual health', 'casual sex', 'sexual fantasies', to name just a few (Bancroft, 2009; Denman, 2004; Butler, O'Donovan & Shaw, 2010). These terms all appear to be imbued with social and moral ideas of what is acceptable or unacceptable. Hall (2011) exemplifies this through her discussion of the problems with the label 'sexual addiction', as she disputes the evidence for the process of 'escalation and withdrawal' and 'powerlessness' that supposedly represents addiction. 'Compulsion' is questioned as this is associated with the repeated 'checking' behaviours associated with obsessive-compulsive disorder; and 'dependency' is queried, due to the widely held view that sex is 'innate' and integral to human existence. The then proposed 'hypersexuality' or 'hypersexual disorder' (Kafka, 2010; Reid et al, 2012) - which was eventually dropped from inclusion in the American Psychiatric Association's (APA) 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), (APA, 2013) - suggested that individuals have too much sex, whereas Hall identifies that a reliance on sex, is not necessarily 'driven by sexual desire' (Hall, 2011, pp. 218), but rather, can be a way of escaping a feeling, or fulfilling a need. This appears to illustrate the difficulties in categorising particular issues according to set criteria, as there is room for considerable variation in meaning and clinical interpretation.

The varying labels used to identify particular sexual problems, go beyond just 'sexual addiction' and are subject to some discussion. Related to physical difficulties are 'sexual pain' disorders, such as, dyspareunia, which technically denotes pain on intercourse, but, as Binik (2005) notes,

can also occur with other non-sexual activities such as: urination, tampon insertion, gynaecological examinations and during sporting activities; and refers to pain of varying intensities, in different physical locations and with diverse aetiologies. Binik (2005) argues, these could be more appropriately classified as a pain disorder, than a sexual disorder. These taxonomical debates highlight the difficulties regarding what is of concern and for whom (for client and/or professional) and stress that the use of 'issue' in relation to sex, is similarly troublesome, as sexual discussions can refer to both problematic and non-problematic sex. For example, a client may view their sexual fantasies as problematic, whereas, the therapist may accept and seek to normalise them (Newbury, Hayter, Wylie & Riddell, 2012). Equally, a client may see their sexual behaviour as non-problematic, while a therapist, due to their own values and biases, may or may not struggle with a client's sexual behaviour or attitudes (Ridley, 2006). This highlights how some of the challenges that differences in attitudes and understanding which may occur between client and CoP, can impact on engaging in sexual discussions.

These preceding examples highlight that the psychological perspective as to when sex is viewed as problematic, differs depending on therapists' approaches to sex and therapy. These therapeutic approaches commonly include one or more of the biomedical, psychoanalytic and social perspectives (Goodwach, 2005; Pilgrim & Bentall, 1999), all of which impact on how sex is viewed (see Chapter 2 for further discussion of this). This study adopts a critical realist perspective, which assumes that 'sexual issues' do exist (see 3.4 for definition of critical realist epistemology). However, it is also important to critically recognise that as the above literature has shown, CoP participants in this study may have very varied views on how they understand 'sexual issues', which can inform practice. Therefore, for the purpose of this research, to incorporate all the possible meanings that participants may cite, in relation to client sexual topics, the use of 'sexual issue' or 'sexual topic', attempts to refer to a 'neutral' term, denoting where discussions of sexual topics have occurred within therapy.

1.4 Defining counselling psychology and its therapeutic aims in relation to sex and sexuality

Counselling psychology shares some of its practices with other 'talking therapy' professional disciplines, including counselling, psychotherapy and clinical psychology. There is some debate as to what makes counselling psychology unique amongst these professions (Orlans and Van Scoyoc, 2009; Strawbridge and Woolfe, 2010), nonetheless, the British Psychological Society (BPS, 2005) has specifically highlighted CoP as having its roots in a person centred, humanistic approach to therapy (BPS, 2005). This emphasises the phenomenological curiosity and willingness to attempt to understand the client's experience, alongside the need to: '*develop models of practice and research which marry the scientific demand for rigorous empirical enquiry with a firm value base grounded in the primacy of the counselling or psychotherapeutic relationship'* (BPS, 2005).

The above quote bears out Strawbridge & Woolfe's (2010) claim that CoP attempts to synthesise two diametrically opposed paradigms; a scientific approach with the humanistic, phenomenological underpinning of the counselling/psychotherapeutic relationship and the importance of 'being-in-relation' with, or understanding and empathising with the client (ibid, 2010, p.5). Further BPS (2005) criteria, highlight that CoPs should engage *"with subjectivity and intersubjectivity, values and beliefs";* practice "empathy" with clients; be aware of the plurality of social contexts and discrimination; and the need to empower. These emphasise the approach of counselling psychology to its work, but does not make clear counselling psychology's specific aims. The BPS careers website, to some extent, clarifies the aims and purpose of CoP within the therapeutic context as:

"...dealing with a wide range of mental health problems" and "work[ing] with the individual's unique subjective psychological experience to empower their recovery and alleviate distress".

(BPS, 2014, 3/8/14)

This suggests that both ‘distress’ and its ‘alleviation’ (via the therapeutic input of CoPs), are relative concepts. A client’s physical experience of sex, sexual feelings or relationships subjectively impacts on how they feel about sex; external circumstances (including relationships) can also impinge on the experience of sex and/or sexual functioning; and a psychological adjustment can be required when a health condition/disability impacts on the body and sex and the individual/couple then has to rethink what sex means to them (Bancroft, 2009). These examples suggest that not all distress can be ‘alleviated’ and that individuals differ on when ‘distress’ becomes unbearable. It may be more prudent to suggest that CoPs goal for ‘empower[ing] recovery’, should be to reduce distress rather than get rid of it. These possibilities for working with sexual topics, raise the question as to how CoPs identify sexual ‘issues’ within the therapeutic context and how it is then therapeutically managed and worked with (or not). Furthermore, for CoPs, the consideration from a psychodynamic perspective, of the processes of erotic transference and countertransference (Lemma, 2003), the sexual feelings of a client towards a therapist and the therapist’s feelings in response to this experience, highlight that how sexual feelings emerge in therapeutic contexts may also need to be considered. These carry the risk of going beyond the therapeutic boundaries, into the realm of violating the therapeutic relationship (Baur, 1997; Celenza, 2010a, 2010b), which stresses the need for CoPs to be aware of their own process and their own sexuality (see 2.5.2 for further discussion of this) and the consequences of how they respond to their clients, in order to work with sexual issues.

The range of examples in which sex presents in therapy (cited above), indicate that for CoPs to work with sex and sexuality, a range of knowledges are required. These include biological, social and psychological knowledge of sex and sexuality (Bancroft, 2009; Denman, 2004); an awareness of diagnostic categories of sexual ‘dysfunction’ and how to address them; knowledge of medications/drugs that can hinder or help sexual functioning (Bancroft, 2009; APA, 2000; 2013);

and different therapeutic approaches to working with sexual presentations in the therapy room (Denman, 2004). This plurality of knowledge fits in well with the principles of counselling psychology, to incorporate and use knowledge from multiple theoretical and research sources.

1.5 Relevance of sex and sexuality to counselling psychology practice

Sex and sexuality do appear to be of relevance to CoPs which has implications for how sexual topics are understood within CoP practice. The diversity of possible sexual issues appear to indicate that CoP, with its scope (as mentioned in 1.4) for drawing on numerous resources, offers potential possibilities for CoP input in working with sexual issues. Firth's (2012) examples of the kind of sexual issues that were presented by 100 randomly selected patients in an NHS psychosexual clinic illustrate this diversity: vaginismus; dyspareunia and vulval pain; low libido; erectile dysfunction; ejaculatory disorders and gender identity disorders. Less common presentations were anorgasmia, high libido, sexual addiction and serial partner abuse. All of these may have different causative factors, which could incorporate biological, social and psychological factors (see 1.3 and Chapter 2). Although these examples are framed within the medical context, the following study illustrates how these topics may vary in contexts that do include some CoPs.

Ford and Hendrick's (2003) quantitative study of 314 American therapists, which included clinical psychologists, counselling psychologists and 'marriage and family' therapists (40%, 22% and 13% respectively), attempted to identify therapist attitudes and client sexual topics. The researchers found that client sexual discussions occurred across all sexualities and ranged from sexual abuse/assault/harassment (67%/20%/18% respectively); 'extramarital' sex (61%); 'premarital' sex (42%); sexual orientation/identity (42%); adolescent sexuality (41%); 'sexual dysfunction' (27%); 'sadomasochism' (3%); 'paraphilias' (6%) abortion; 'group sex' (1%); and 'casual sex', 'pornography' and 'open marriages' (Ford & Hendrick, 2003). The labels attributed

to these wide-ranging topics suggest a particular cultural and moral context that these discussions emerged from and could reflect the researchers' own views. These categories do, nonetheless, suggest that across the spectrum of therapeutic practitioners that are not sexual specialists (including CoPs), sexual discussions do occur in the therapy room. These findings indicate that CoPs' can expect to encounter client sexual issues in their clinical work; and that CoPs may also carry sexual assumptions that could impinge on how they work with their clients. The Ford and Hendrick (2003) study also suggests that therapist awareness of lesbian, gay, bisexual and transgender (LGBT) issues are particularly required for the therapeutic context. 7% of the therapist participants identified as gay, lesbian or bisexual (LGB), while 42% of the therapist sample had encountered LGBT clients. This suggests that at least 35% of non-LGB identified therapists (including CoPs), encountered clients who identified as LGBT. McNally and Adams (2000) and Armstrong and Reissing (2013) have highlighted the prevalence of sexual issues in lesbians, gay men and bisexuals (LGB), albeit, fewer studies have been conducted regarding this population group. It has been found that LGB clients' experience of homophobia and heterosexism in society increases their probability of developing mental health problems and is compounded by potential homophobia and heterosexism when seeking therapeutic support (Cochran, Sullivan and Mays, 2003; Department of Health, 2007; Warner, McKeown, Griffin et al, 2004). The potential higher likelihood of encountering LGBT clients, indicates a level of awareness and knowledge of LGBT issues is needed by practitioners working with this client group.

While attitudes to non-normative sexualities do vary, attitudes towards homosexuality by therapists, including possibly, counselling psychologists, has been highlighted in Bartlett, Smith and King's (2009) findings. They identified that 222 (17%) therapists (including British Psychological Society members, which can include CoPs) they surveyed, had utilised reparative/conversion therapy as a means to assist clients troubled by their same-sex attraction,

to become 'heterosexual', in the absence of efficacy for this approach. This study acknowledges that heterosexual therapists do encounter clients with non-normative sexualities and supports the need to tackle prejudice and provide culturally sensitive LGBT affirmative therapy. This includes recognising when sexual orientation and identity is relevant to therapeutic discussion, or not; and facilitating LGBT clients in accepting their sexual identity through negotiating and resolving any conflicts arising from external homophobia/biphobia/transphobia and heterosexism and/or when they internalise these attitudes towards themselves (Davies, 1996; BPS, 2012).

The possible gaps in awareness relating to sexuality, suggest that professional training is insufficient in equipping non-CoP therapy professionals to competently explore sexuality and sex related topics with their clients. The following research studies of therapists highlight some of the difficulties that may also apply to training CoPs to work with sexual presentations. Riessing & Di Giulio's (2010) study of 188 Canadian clinical psychologists, found that they lacked formal course training on addressing client sexual issues, despite a range of sexual topics being discussed with clients. These included discussions on safer sex, discrepancies in couples' sexual desire, lack of sexual satisfaction, sexual desire 'disorders'; 'gender identity disorder'; other sexual 'dysfunctions', such as premature ejaculation, 'paraphilias', sexual aversion disorder, vaginismus and dyspareunia and male orgasmic disorder. The researchers concluded that levels of practitioner comfort in initiating sexual discussions appeared to be directly linked to the amount of training they had. Harris and Hays (2008) quantitative study of 175 'marriage and family' therapists identified that feeling comfortable to approach sexual topics was more important than sexual knowledge, although, sexuality training and supervision was positively linked with comfort in sexual discussions. This also suggests a possible distinction between therapists' training in sexual knowledge and whether training makes therapists feel comfortable to approach discussions about sex.

Therapists' willingness to address sexual issues also appears to be related to their assumptions as to whether or not they expect sexual issues to apply to their clients. This was despite evidence that sexual issues are often hidden or unspoken by clients, unless therapists directly screen for them. CoPs are known to work in diverse contexts (Orlans and Van Scoyoc, 2009; Woolfe et al, 2010), including psychiatric services and within this sphere, evidence suggests that sexual issues are relevant. Two studies suggest that affected clients do not always raise the sexual problems that may impact on their mental health. Problematic sex can be a causative factor in depression, or a consequence of depression and/or the side effects of taking medication for it (Hook & Andrews, 2005; Östman, 2008). In relation to those experiencing psychosis, D'ardenne & McCann (1997) claim that mental health professionals have neglected their clients' sexual needs and problems. The rates of sexual dysfunction amongst those with schizophrenia, reportedly range from 30-80% in women and 45-80% in men and cover the range of DSM sexual dysfunction categories (Marques et al, 2012). The authors note that these problems have usually been attributed to the effects of psychiatric medication, but their study suggests that sexual problems can be a precursor to the onset of first psychosis, as a prodromal (pre-psychosis state). These findings suggest that within some of the contexts that CoPs have been known to work in, there is a possible need for therapeutic practitioners to be proactive in making the client comfortable to raise any sexual concerns, by breaking the implied unspoken taboo. These findings point to a possible implication that some therapeutic issues take precedence over others and also raise questions as to how CoPs can approach identifying if clients have any sexual concerns.

The effects of child sexual abuse provide a further example of how commonly sexual issues may be relevant in mental health settings. Spataro, Mullen, Burgess, Wells and Moss (2004) identify that adults presenting with psychiatric issues reported a higher likelihood of past child sexual

abuse (CSA), although, this retrospective study suggests correlation rather than causation. A different, longitudinal study of 1265 children, from birth to 25 years old, demonstrates that past child sexual and/or physical abuse is more positively correlated with the development of mental distress (Fergusson, Boden & Horwood, 2008). These results confirm that it is more likely that sexual abuse may be a subject that warrants exploration in therapy, either as something that affects mental health and/or affects sexual functioning and relationships. It therefore appears important for CoPs to assess for sexual problems and to explore how these emerge, both within and outwith psychiatric populations.

The sexual taboo referred to above, relating to practitioner hesitance to enquire about sexual issues, appears to exist in a range of arenas and presents problems when attempting to discuss sexuality. This has created challenges in educating young people in relation to sex, sexuality and relationships (Measor, 1996; 2004); and in relation to disabled people, who are often popularly perceived as asexual (Kim, 2011). Dialogue around disabled people's sexual feelings and activities are not necessarily attempted, or if it is, the information can be limited (Shakespeare, Gillespie-Sells & Davies, 1996). This is borne out by Parritt and O'Callaghan's (2000) identification of therapist discomfort when discussing disabled clients' sexuality.

The reluctance to broach sexual topics is not restricted to solely therapeutic practitioners and also applies to clients and wider society. Various contributors have been noted by Stevenson (2010), who proposed that client reticence to discuss sex and/or sexuality is related to the fear of the therapist's reaction and/or perceived power imbalances between client and therapist, due to factors such as gender, age, race, disability and sexual orientation. Riggs & das Nair (2012) argue that the intersection of two or more of these cultural identities can create complex power and cultural dynamics between clients and therapists. These dynamics can affect the therapeutic relationship and make sexual discussions problematic. For example, das Nair and

Thomas (2012) highlight that when a non-heterosexual person from a black, Asian or minority ethnic (BAME) community encounters both racism and homophobia they will attempt to negotiate their multiple identities and work out where they feel accepted, in society and/or by their therapist. Bhugra and Wright (2004) have also highlighted how cultural meanings of sex can differ according to gender and ethnicity and raise the need for sensitivity to this when working with 'sexual dysfunctions'. Riggs and das Nair (2012) argue that therapists need to acknowledge and embrace the complexity of multiple identities and dynamics in order to work with clients. This highlights the need for CoPs to be aware of the layered complexity that multiple identities may have on the understandings of sex and sexuality.

To conclude, this introductory chapter has highlighted how sex, sexuality and gender are separate but interlinked concepts that are closely bound up with individuals' relationship with both their self and the world around them. Sex has been identified as considerably more diverse than just penile-vaginal intercourse; and its related concept of sexuality has also been argued to have multiple meanings that are dependent on the social, historical and political context of the time. Identifying what sexual topics or issues arise in the therapeutic context and how they are relevant to CoP, is similarly problematic, due to differences in professional perspectives as to what constitutes a sexual 'problem' and whether sex in itself needs to be considered problematic when being discussed in therapy. The problems with identifying and working with sexual issues appear to be compounded by the lack of clarity in CoP's therapeutic aims (see 1.4). This points to the ongoing tension within CoP, between balancing the influence of the medical model and the more humanistic and socially aware theoretical influences advocated in CoP training.

This introduction has also noted that while most research in this area has focused on non-CoP therapists, they are also relevant for CoP practitioners. Findings have suggested that sex often

appears to present in the therapeutic context despite the lack of specialist formal therapeutic training in sex and sexuality. There also appears to be some uncertainty regarding when sex may be relevant and when it is appropriate to enquire as to how a client experiences sex. Therapist uncertainty to discuss sex also appeared to be connected to a lack of understanding of clients' cultural backgrounds. Furthermore, the power dynamics embedded within the client-therapist relationship and how sexual and/or erotic transference may be managed in the therapeutic context may contribute to ambivalence around this aspect of the work. Attitudes to non-heterosexual sexual identities can also be problematic in facilitating non-pathologising sexual discussions. Chapter Two will go into these in more depth and address the different professional understandings of sex, gender and sexuality that have influenced therapeutic and counselling psychology practice.

The above introduction to the literature review highlights how CoPs may be suited to working therapeutically with sexual topics. However, as CoPs are not psychosexually trained, this raises issues as to how they work with sex and sexuality presentations, given that the evidence indicates that CoPs do encounter sexual issues and are not uncommon. The existence of psychosexual therapy professionals, appears to place sex and sexuality into a 'specialist' field of knowledge, despite the above literature signifiying that sex and/or sexuality appears to permeate much of human life and appears to be an inevitable part of social and personal culture – whether a person regards themselves as sexual or not (see section 2.5.1). It is therefore important to identify how CoPs understand sex and sexuality in relation to their therapeutic work.

CHAPTER 2 LITERATURE REVIEW

2.1 Overview of literature review

This literature review expands and develops the introduction. The decision as to which aspects of the extant literature to include, was based on what would be relevant to understanding sex and sexuality within the context of counselling psychology (CoP) practice. To this end, this literature review examines how different theoretical perspectives have understood sex and sexuality and their implications for CoP practice. These theoretical perspectives cover the biomedical, psychological and sociological paradigms and are discussed in relation to the researcher's critical realist stance that informs this study. The literature review will then examine specifically how CoPs work with sex and sexuality in practice and the relevance of this to the critical realist perspective of this research. This chapter will finally consider how this proposed research relates to other work in the field, further developing the rationale for this study introduced in Chapter One.

Literature searches were conducted via PsychInfo, Web of Science (and others) and known specialist publications, such as the 'British Journal of Sex and Relationship Therapy'; 'Sexualities' amongst others. The keyword 'sex', had to be accompanied by other words, or results relating to gender differences were presented. Similarly, sexuality as denoting sexual orientation often emerged. Consequently, other accompanying words had to be searched for. These included: 'sexual knowledge'; 'sexual understanding'; 'Sex therapy'; 'sex history'; 'sexual presentations', 'sex counselling psychology'; 'sex counselling'; 'sex therapeutic training'; 'sex counselling psychology training'; 'sexuality counselling psychology; 'sex psychiatric settings', amongst others. Some search terms yielded more results than others and the researcher had to filter what was relevant to the current study.

2.2 Late 19th to early 20th century research on sex and sexuality

This section highlights how biological sexual knowledge first started to influence therapeutic understandings of sex and sexuality and critiques some of the problems identified with the biomedical approach to addressing sexual problems. These biological influences occurred both before and after Freud's psychological theories (covered in 2.3). 'Sex', as a field of study did not exist until relatively recently and neither did the word 'sexuality' (Weeks, 2010). These became a more recent subject of interest, with relevance to psychological understanding, in the late 19th/early 20th Century (Weeks, 2010). This, Week's (2010) argues, was influenced by the increasing recognition that sex and sexual conduct could be regulated through social, familial and organisational structures which were enhanced by the emerging sociological, biological and psychological insights into sexual behaviour. These insights emerged initially, through medical and scientific researchers, including Krafft-Ebing (1840-1902) Havelock Ellis (1859-1839) and Kinsey (1894-1956), who aimed to identify and categorise a variety of different sexual activities and sexual expression, into taxonomies. For example, Ellis' 'Studies in the Psychology of Sex' (1897-1910), categories included: homosexuality (sexual inversion), menstruation, masturbation (autoeroticism), the process of sexual arousal (tumescence) and transgender issues. These terms were representative of the time and did influence later key professionals, including Freud (more on Freud in section 2.3), who drew on Ellis' terms of narcissism and autoeroticism (Laplanche & Pontalis, 1988). The process of taxonomisation enabled sex to become a subject of interest and discussion to medical and therapeutic professionals. The next paragraph examines how Kinsey's research in the 1940s-50s changed the understanding of sex.

Kinsey et al's (1948; 1953) US research as a sexologist, on male and female human sexual behaviour within America, played a pivotal role in making sex a visible subject and challenging both the public and professional assumptions about sex, at the time. The approximately 10,000 men and 6,000 women interviewed (Kinsey et al, 1948; 1953) exposed people's moral values and

expectations regarding what people thought others did sexually, in contrast to what actually occurred. He revealed (amongst other things) the prevalence of masturbation in women (62%); premarital sex (both sexes, over 50%); homosexuality (over half of all men reported at least one homosexual experience to orgasm) and oral sex which, at a time when oral sex and homosexuality were illegal, was culturally, highly taboo (Kinsey et al 1948; 1953; Bancroft, 2004; Goodwach, 2005). The findings that 4% of men and 2% of women identified as always attracted to the same sex, while others also reported some same sex experiences, led to the construction of the Kinsey Heterosexuality-Homosexuality Scale (later known as the 'Kinsey scale'). This sought to normalise homosexuality as part of a natural continuum of sexuality, throughout life, from homosexual to bisexual to heterosexual (Kinsey et al, 1948; Bancroft, 2004). This eventually influenced the UK decriminalisation of male homosexuality in 1967 (Bancroft, 2004). Kinsey's social and legal influence has therefore been extensive, both in relation to perceptions of homosexuality within the mental health field and for paving the way to understand sexual behaviour in the context of CoP.

Furthermore Kinsey's identification of different sexual behaviours including 'petting' (non-intercourse sexual behaviour), and 'intercourse'/'coitus' in premarital, marital and extramarital situations (Kinsey et al, 1948; 1953), reflected not only a biological perspective, but a sociological approach to studying sex and relationship patterns. Gender, religion, education, upbringing, and economic elements, were considered important as factors in the presentation and variation of sexual behaviour. However, he was criticised for his recruitment techniques and for including only White people in the data (Jackson & Scott, 2010). Ethnicity and culture were therefore not considered important, albeit, the substantial size of the data gathered, is still of value and has left a lasting legacy.

In contrast to the preceding studies, the lesser known smaller scale, British so-called 'little Kinsey' study conducted in 1949 by Stanley and the 'Mass-Observation' project, was not published in its entirety until 1995 (Stanley, 1995). This research pioneered a somewhat different sampling and data gathering strategy to identify sexual trends that attempted to address some of the cultural biases evident in previous sex research. A random sample of 2052 people, were quantitatively surveyed on their attitudes and knowledge relating to forms of sexual and relationship conduct. This was combined (unusually for the time) with a qualitative participant observation, of public sexual behaviours (such as in dance halls of the time). Finally, those who observed these sexual interactions (the National Panel of 450 people) were also interviewed regarding their sexual attitudes and behaviour. The combination of quantitative data with qualitative depth, gave rich data, particularly when governmental statistics (such as numbers of abortions/use of contraception) and gender, social class, religious belief and other social factors were taken into account. This attempt to combine qualitative and quantitative data helped to illuminate sexual attitudes and behaviour, which, if replicated today, would have the potential to shape CoPs work.

The findings from the Mass-Observation project allowed variation in the data to be understood within the then sociopolitical context. For example, older people were more likely to be happier with 'informal' methods of sex education (such as word of mouth) than young people, of whom, a third had received formal sex education, which reflected the generational shift in attitudes. Similarly, a higher level of education was found to correspond with being more informed about sex and birth control and more supportive of the need for sex education. The 'Mass-Observation' organisation that conducted this historical research also highlights how quantitative data and the resultant sexual meanings, cannot be considered in isolation from its social context.

While the previous research looked at sexual behaviour in the context of general trends, Masters and Johnson (1966; 1970; 1979) and Masters, Johnson and Kolodny (1982) shifted the focus to investigate more specifically, the biological and physiological mechanisms activated during sex. Their identification of the different stages of the sexual response cycle, pre-orgasm, during, and post-orgasm, facilitated the recognition of sex as a pleasurable experience. This supported Kinsey et al's (1948; 1953) research that highlighted the differing sexual activities and levels of masturbation and orgasm experiences of women, as well as the presence of homosexuality in both men and women. Masters and Johnson's understanding of physical sexual responses also contributed to the identification of what they considered to be 'normal' sexual behaviour, which allowed them to examine what happens when sexual 'problems' occur. This has raised implications for how both 'healthy'/'normal' sex and 'unhealthy' or 'dysfunctional'/'abnormal' sex are defined in the literature (see 1.3) and these definitions have altered according to the moral values associated with the time periods in which they emerged (Firestone, Firestone & Catlett, 2006). Nonetheless, the knowledge gained from research on sexual issues is still valuable as it can help CoPs' demystify the sexual process when gaps are identified in client's sexual knowledge that hinder their ability to have and/or enjoy sex (Brewster and Wylie, 2008).

The biomedical understanding of sexual 'problems' has highlighted problematic issues relating to how therapy is administered. The biomedical model appears to problematise sexual behaviour according to medical diagnostic criteria which reflects somewhat fixed ideas regarding how sex should be understood. This is exemplified through the different versions of the diagnostic and statistical manual of mental diseases (DSM). The DSM (American Psychiatric Association, 1980, 2000; 2013) and/or the World Health Organisation's, International Classification of Diseases (ICD 10; World Health Organisation, 2010). These professional guides to mental health diagnoses have affected the understanding of sex, up to the present day. The

sexual categories included in the DSM were influenced by Masters and Johnson's (1966; 1970; 1979) and Masters et al's (1982) work on the biological changes during sexual activity and Kaplan's (1977) work on sexual desire, which led to problems with sex being defined as deviations from the identified four stages of desire, excitement, orgasm and resolution. These are considered in the DSM IV TR (APA, 2000) as 'disorders' that constitute: *'a disturbance in the processes that characterize the sexual response cycle or by pain associated with sexual intercourse'*. (APA, 2000, pp. 735). There appears to be an assumption here, that the act of sex is solely penile-vaginal sex (PVI). The DSM 5 (APA, 2013) responded to this, by incorporating 'disorders' as part of a wider group of 'dysfunctions' and gives a broader reference as to what sex is, by taking out the term sexual intercourse: '*Sexual dysfunctions are a heterogeneous group of disorders that are typically characterised by a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure'* (APA, 2013, pp. 423). There seems to be an absence, in both the above definitions, as to what 'healthy' sex, might be. 'Sex' in this context, appears to be defined by what is deemed 'unhealthy' or 'dysfunctional'. The opposite view, of 'sexual health', comes from the World Health Organisation (WHO):

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. (World Health Organisation, 2006, p. 5).

This definition suggests that embedded in the notion of how meanings of sex 'should' be understood, is that 'sex' is not only related to physical functioning, but is also considered a positive, psychological, emotional and social activity. It is implied that to engage in sex 'healthily', depends on having a safe environment for sexual exploration and development. This

considerable contrast with the DSM's medicalisation of the sexual body and its functioning does assume that sex is either negative or positive. This binary stance does not acknowledge that sex can also contain degrees of positive and/or negative. This difficulty in identifying what is 'healthy' or 'unhealthy' sex, is critiqued by Conrad & Schneider (1992) who note that the medical model converts and classifies culturally relative notions of 'deviant' behaviour into different types of 'sickness' to be managed by medical 'experts'. This appears to invite CoPs' to question how they, as health practitioners, may make assumptions as to what 'sex' is and what a 'sexual problem' is, which may have implications for CoPs and how they may work with sexual topics.

Furthermore, from a counselling psychology perspective it could be argued that the medical model also appears to isolate the individual and their sexual issue from their social world (Tiefer, 2010). This disparity seems to create difficulties in how sex can be worked with, therapeutically. Tiefer (2010) argues that the medical model considers the 'sexual dysfunction' as solely the problem of the individual, whilst omitting the impact of how the sociocultural environment can contribute to the development of 'sexual disorders'. The biomedical perspective is therefore problematic as sex is not a straightforward concept to define and carries considerable social bias. This is illustrated through the American Psychiatric Association's 1974 retraction of homosexuality as a mental disorder, from the DSM. The WHO's ICD 10, followed suit, 18 years later, in 1992. The slow pace of change is demonstrated by the main UK (including the BPS) therapy regulators recent declaration of their condemnation of conversion therapy, the misguided attempt by therapeutic practitioners' to 'correct' or convert same sex attraction into heterosexual feelings (United Kingdom Council for Psychotherapy, 2015).

Further evidence of social bias and changing mores regarding what sex involves, can be found in the changing definitions of the proposed, rejected and included sexual categories in the DSM 5 (2013). The rejection of the inclusion in the DSM 5 of anodyspareunia (spasm of anus during anal

sex) in both men and women (Hollows, 2007; McNally & Adams, 2000; Simon Rosser, Short, Thurmes & Coleman, 1998; Štulhofer & Ajduković, 2011); and the DSM 5's controversy for pathologising sadomasochistic sexual behaviour as part of 'sexual masochistic disorder' and 'sexual sadistic disorder' within the paraphilias (American Psychiatric Association, 2013; Shindel & Moser, 2011) and may reflect the biases of those who created the definitions (Davies, 2013). The biomedical perspective has also persisted in the context of conducting therapy, particularly in relation to pharmacology and sexual dysfunction. Although biological contributors to 'sexual dysfunction' can and do exist (Bancroft, 2009), at times, the biomedical approach has been at the expense of exploring psychological factors contributing and/or causing the problem (Goodwach, 2005).

2.3 Psychological perspectives on sex and sexuality

Freud's (1856-1939) historically radical theory that sex was at the root of all psychological problems, brought sex and sexuality on to the Western therapeutic agenda and coincided with the development of psychoanalysis as a means to address psychological issues. Freud's drive theory of libido and the psychosexual stages; the oedipal complex and its female equivalent, the feminine oedipal complex (named as the Electra complex by Jung); and his ideas on perversion and inversion (Freud, 1900/1953a; 1905/1953b; 1914/2001; 1920/1962; 1923/1961; 1977) have since been criticised substantially, especially in regards to his views on homosexuality and his view of women (Eichenbaum and Orbach, 1982; Hodges, 2010; O' Connor & Ryan, 1993). Freud's theories on the aetiology of homosexuality did change over time. His proposal that everyone is innately bisexual and that homosexuality occurred when a person became 'stuck' in the phallic or genital stage of psychosexual development was contradicted by his implication that homosexuality is non-problematic (Hodges, 2010). Nonetheless, the theories pertaining to homosexuality as a psychological disorder, permeated the culture of psychoanalysis and subsequently, psychotherapy (as evidenced in 2.2 by the use of reparative/conversion therapy).

Furthermore, the Oedipal and Electra complexes have heavily influenced both psychotherapy and society and have been criticised (Eichenbaum and Orbach, 1982; Hodges, 2010; O'Connor and Ryan, 1993). The Oedipal and Electra complexes proposed that deep sexual rivalries were unconsciously embedded in children as a desire to 'kill' one parent to be with the desired other parent. Freud suggested that this happens for different reasons in boys and girls. In the Oedipal complex, the boy unconsciously wants to kill the father because he is a threat to being with the mother; whereas, in the Electra complex, the girl unconsciously resents the mother because she lacks a penis, and therefore desires to be closer to her father (Freud, 1900/1953a; 1905/1953b; 1977). This implied that girls/women were inferior to boys/men. A girl could be deemed (in Freud and Jung's eyes) to be unable to want something in her own right and has to be positioned in terms of what she 'lacks' in relation to boys and/or men (Eichenbaum and Orbach, 1982). However, Freud's inherent sexist and heterosexist assumptions were a product of their time and location in the Western world, that was, and still is (albeit, to a lesser extent) patriarchal (dominated by men), which makes heterosexist assumptions about how sexuality is or should be expressed (Eichenbaum and Orbach, 1982). Freud did eventually move away from his sexual theories to reframe libido as life energy (Freud, 1920/1962; Goodwach, 2005).

Contemporary ideas have also countered the more traditional Freudian psychotherapeutic concepts of sex. Theories on subjectivity and intersubjectivity, the awareness of how therapist and client mutually affect each other (Lyons-Ruth, 1999: Stolorow & Atwood, 1997), in conjunction with the poststructuralist ideas of Foucault (1981; 1986; 1988) and Butler (1990), has provided a means of utilising psychoanalytic theory to examine and critique the unconscious ideas that allow sexist and heterosexist ideas to exist (Hodges, 2010; O' Connor & Ryan, 1993). Thus, poststructuralist and gay affirmative approaches have revised existing psychological theories that are traditionally seen as pathologising homosexuality, to be used in non-oppressive ways (Davies, 1996).

A different understanding of the psychology of sex and working with it therapeutically, emerged with Master's and Johnson's (1966; 1970; 1979) and Masters et al's (1982) identification of 'sexual problems' related to the sexual response cycle. Their creation of sensate focus techniques for working with problematic sexual and communication issues between couples (Masters & Johnson, 1970) are still in use today (Bancroft, 2009; Goodwach, 2005). This shifted therapeutic work away from a psychoanalytic method into a more practical cognitive-behavioural direction, with a reportedly reasonable level of success (Masters et al, 1982; Berry, 2013; Southern & Cade, 2011). However, Masters and Johnson have attracted criticism for their recruitment process (Tiefer, 1991) and the assumption that the sexual response cycle is as linear as they claim, particularly in women (Basson et al, 2000; Levin, 2008). Furthermore, their use of reparative therapy as a means to cure homosexuality (Masters and Johnson, 1979; Schwartz and Masters, 1984) has been discredited due to possible faked claims for its effectiveness (Bartlett et al, 2012).

The changes in psychological approaches to working with sex appear to reflect the changing forms of professional knowledge. The notion of sexual desire was not initially included in Masters & Johnson's model of the sexual response cycle (Goodwach, 2005). Sexual arousal and desire's importance was highlighted by Kaplan (1974; 1995), who advocated an integrative cognitive-behavioural and psychodynamic approach that paid attention to relationship and therapeutic dynamics (where needed). The rise of pharmacology (see 2.2, p.32) also means behavioural tasks can be combined with pharmacological input (Berry, 2013). These existing knowledge bases have been criticised as outlined in the next paragraph.

Feminist critics of the biomedical approach to sex therapy suggest that the definitions of sexual disorders need to change, to reflect people's individual experiences. The 'New View' of sex

therapy proposed that the purpose of sex therapy was to address: '*discontent or dissatisfaction with any emotional, physical, or relational aspect of sexual experience'* (Kaschak and Tiefer, 2001, pp. 86). This less prescriptive stance to sexual dissatisfaction was designed to open up wider thinking and meanings related to sex. Since Tiefer, other various integrative therapeutic approaches have also been proposed and contemporary theories to address sexual issues now advocate a biopsychosocial approach (Denman, 2004; Goodwach, 2005). This counters the emphasis on sexual 'problems' as being attributed solely to the individual and advocates the therapeutic consideration of the individual's upbringing, sexual history and social factors to be taken into account when working with sexual issues (Denman, 2004; Goodwach, 2005).

2.4 The social context relating to meanings of sex

The importance, for CoP, of understanding how the sociocultural context impacts on meanings of 'sex' (O'Donovan & Butler, 2010; see section 1.2), is supported by research which also counters the biomedical perspective. Peterson & Muehlenhard's (2007) study elicited qualitative answers from students as to what they thought were: *"almost but not quite sex"; "just barely sex"; situations where there was "uncertainty";* or *"disagreement about whether the experience qualified as sex"* (Peterson & Muehlenhard , 2007, pp. 258), highlighted the complexity and confusion of definitions of sex. Participants' understanding of sex differed according to their own sociocultural assumptions and what they thought other people wished to know. For example, some female participants considered oral sex as 'not quite sex', as this offered a means to retain their virginity (which, it was suggested, was highly prized in their social world) and maintain their reputation for prospective relationships and/or marriage. Others spoke of starting 'sex' but ending abruptly or having negative sexual experiences. These individuals were more likely to consider it 'not sex' and/or acknowledge their uncertainty surrounding this, because it was still sexual activity. This research suggests that CoPs need to consider the impact of how the social context influences meanings of sex and how sex is then presented to others; this also implies

that both client and therapist may have different understandings of sex which may need addressing in the therapeutic context.

Simon and Gagnon's (2003) sexual script theory (briefly outlined in 1.2) proposed a model for how individuals process their understanding of sex and their own sexuality and negotiate their sexual conduct, through a combination of social and psychological processes. People's social and self sexual scripts create 'cultural scenarios' to ascertain what is acceptable sexual conduct. The conflict between personal sexual feelings, thoughts and desires (the self sexual scripts) and perceived appropriate sexual conduct, activates 'intrapsychic' scripts as a means to reconcile conflicting information. Individuals can then reconfigure their understanding of sex and how they perceive and construct their sexual self in relation to society. The authors propose that this means that private and personal sexual desires cannot be separated from the social context. For example, where sex is closely regulated, different responses and degrees of potential alienation or 'anomie' from society will be provoked, than in societal contexts where sex and sexuality are less regulated. This theory implies that individuals' personal reactions to societal rules can have a significant impact on how sex is thought about and offers CoPs a way of thinking about people's motivation for different kinds of sexual conduct.

Plummer (2003) complements Simon & Gagnon's ideas, by arguing that sex and having a sexuality has become a process of regulation by society. His notion of 'intimate citizenship' stresses that sex and the expression of sexuality are degrees of the intersection between 'social and private sexual spheres'. For example, moral ideas govern the expression of sexuality and by implication, what is sexually acceptable, as illustrated by legislative rules regarding who can get married and when and how people can divorce; and when sex is deemed coercive. Rules about the practice of sex are transmitted from generation to generation, *'through the reproduction of gender relations'* and the *'patterning of power relations between children and adults'* (ibid, p.

70). This, Plummer argues, occurs in numerous arenas of social and personal life. Simon and Gagnon's and Plummer's sociological, symbolic interactionist perspectives give explanations for how social norms, values and modes of regulation impact on the construction of sex as having a particular meaning for each individual. As CoPs are a part of society, they are not immune to these norms, values and regulatory ideas about sex and their sexual understandings therefore warrant exploration due to the potential impact of their understandings, on clients.

Poststructuralists critique biomedical and sociological ideas by attempting to explain, not only how these sexual constructs have emerged, but to deconstruct them (Foucault, 1981; 1986; 1988). Embedded within this, is the notion of how power, by individuals as well as historical, political and social structures, influence the perpetuation of constructions of sex and particular modes of sexual practice and conduct. These appear to regulate the social discourses of what, sexually, is perceived as socially acceptable or not. Poststructuralist ideas are popularly used by queer theorists (Butler, 1990; Weeks, 2010) to question and deconstruct how moral binary notions of right/wrong or normal/perverse, develop. For instance, poststructuralists would question why the institution of marriage is deemed as more important than polyamory (Finn, Tunariu & Lee, 2012). Therefore, no assumptions should be made regarding the fixedness of gender and/or sexuality, as the concepts are fluid and changeable, as Butler (1990) proposed in her idea that gender is a 'performance' conducted in relation to dominant norms of heteronormativity (the assumption that heterosexuality is the 'normal' and only sexuality).

In addition to challenging heterosexism (the assumption that heterosexuality is the better form of sexuality) and homophobia, queer theorists encourage the need for recognition, by society, including CoPs, of a wider, more complex understanding of sexualities that encompass the whole of the gender and sexuality spectrum. These include, but are not restricted to: asexuality (Bogaert, 2004; Carrigan, 2011; Przbylo, 2011); bisexuality, polyamory and kink, or, bondage,

submission/sadism, domination and masochism (BDSM); and transgender identities (Richards and Barker, 2013). These are frequently referred to in the literature as minority sexualities (Davies & Neal, 1996), which suggests that they are less visible and that therapists are likely to be unaware of issues relating to these sexualities/identities.

Poststructuralist theory, therefore, advocates that multiple discursive constructions of sexuality are possible and this needs to be kept in mind by therapists rather than assuming shared assumptions with their clients. While this does pose some important questions about the assumptions that society and its inhabitants make, by sustaining a relativist stance, it cannot acknowledge the sustained reality of an individual's experience. Consequently, a critical realist perspective (see 3.4) is more useful for this study as it recognises that 'sex' is a real thing that does exist, whilst acknowledging the reality that the social context impacts on the multiple experiences and understandings of sex. The reality of individuals' experiences and understanding, as it is seen by those individuals, is therefore recognised (Willig, 2008; Lawthom and Tindall, 2011, Pilgrim & Bentall, 1999). Acknowledging the presence of non-normative sexualities (explored in the next section) is therefore in keeping with a critical realist perspective.

2.5 CONTEMPORARY ISSUES RELEVANT TO COUNSELLING PSYCHOLOGY

This second half of the literature review examines contemporary issues identified by recent research related to working with sex and sexuality, that has relevance to CoP practice. This covers the range of sexual diversity, the development of self awareness of therapists/CoPs and the impact of sexual attitudes and feelings in the therapy room. The literature review concludes with the rationale, aims and objectives of this proposed study.

2.5.1 Sexual diversity

The invisibility of lesser known non-normative sexualities (outlined in the previous section), does not mean they do not exist or are less valid and may present challenges for CoPs' therapeutic work with clients. The presence of heterosexism, homophobia and biphobia can affect the non-recognition of bisexual relationships and identity as people in same-sex or opposite-sex relationships are assumed to be heterosexual or homosexual and not bisexual (Barker, Bowes-Catton, Iantaffi, Cassidy & Brewer, 2008). When counselling psychologists carry these assumptions into their client work, it could hinder the complexity of understandings of sexual practices, orientation and identities (Barker, Bowes-Catton, Iantaffi et al, 2008; Barker & Langdridge, 2008; BPS, 2012).

Similar issues arise with non-monogamous relationships and BDSM. Non-monogamous or polyamorous relationships, with multiple concurrent sexual and/or romantic partners, are often viewed in mononormative ways (the assumption that monogamy should be the norm) and can '*challenge the practitioners' personal values'* (Berry & Barker, 2014, p.1). Berry and Barker (2014) identified that openness to non-monogamy can open up new and varied ways of relating that allow both non-monogamous and monogamous individuals to question and challenge what they want in their relationships. Likewise, kink or BDSM sexual activities and identities have challenged what is considered 'normal' and socially acceptable (Barker, Iantaffi & Gupta, 2008; Bridoux, 2000; Connan, 2010; Denman, 2004). This is illustrated by the mainstream popularity of the Fifty Shades trilogy of novels (James, 2012), which reflects the wider public desire to acknowledge hidden existing areas of interest and/or introduce new aspects to their sexual lives. However, Attwood and Walters (2013) and Barker (2013) have criticised the accuracy of the depiction of the BDSM relationship portrayed in these novels, particularly in regards to the law, safety and consent. The potentially risky and serious implications of misunderstanding how to

conduct BDSM safely, applies to both clients and CoPs and could affect how a CoP responds to a client engaging in BDSM (Barker, Iantaffi & Gupta, 2008; Bridoux, 2000; Connan, 2010).

Asexuality is a lesser known identity/relationship style that relates to the absence of sexual feelings, after excluding physical and/or psychological contributors (Przbylo, 2011). Bogaert's (2004) study of sexual attraction in 18,681 participants found that 1.05% selected *'I have never felt sexually attracted to anyone at all'*. Research in this area is small, though, it is understood that romantic and sexual attraction can be separated. An asexual person can still have a romantic but non-sexual relationship with a partner (Carrigan, 2011). As this form of sexuality is not well-known or understood, this could mean therapists do not consider it as a possibility and/or may automatically assume it has a psychological cause. A different meaning of asexual refers to the socially assumed desexualisation of disabled people which is related to a lack of knowledge about disabled people's capacity to be sexual. Nonetheless, this should not detract from a disabled person's right to self-identify as sexual or asexual (if they wish to), rather than having a label imposed on them by others (Kim, 2011). The range of sexual diversity identified here, suggests that CoPs need to be aware of such issues in relation to clients presenting with non-normative forms of sexuality.

2.5.2 Counselling psychologists and the therapist's use of self: Developing self awareness

The differing understandings of sex, highlighted so far, reflect Hodges (2010) argument that no therapeutic practitioner can be outside of the prevailing social norms that they and their clients are embedded in; and that CoPs need awareness of how these norms create and/or reinforce, consciously and/or unconsciously, ideas of how sex 'should' be, for both client and practitioner. Therapist's own feelings and attitudes can potentially manifest as reactions to and judgments of clients' sexual and relationship behaviour and/or as sexual feelings (Ridley, 2006). These suggest a necessity for therapists' to distinguish feelings that are genuine responses to the client and not

their own feelings and biases projected on to them (Klein, 1946; Rønnestad & Skovholt, 2001). This highlights how CoPs' own personal self is involved in the practice of clinical work.

The development of self-awareness can emerge in different ways and is reflected in the CoP course requirements for trainees to undertake mandatory personal therapy, participate in experiential process groups and maintain reflective journals (Orlans and Van Scoyoc, 2009; Rizq, 2010). In particular, numerous studies have revealed the effect of personal therapy on the therapists' and/or CoPs' personal development and how this affects the therapeutic relationship in reducing clients' mental distress (Grimmer and Tribe, 2001; Kumari, 2011; Macran, Stiles and Smith, 1999; Rizq and Target, 2008a; 2008b). Furthermore, it has been identified that trainee therapists' use personal therapy to disentangle their own feelings from their clients' feelings and experiences (Grimmer and Tribe, 2001). However, this process of disentanglement by critical self-reflection or reflexivity (Bager-Charleson, 2010; Hedges, 2010) is not specific to sexual attitudes and responses. This suggests that as the topics trainee CoPs can discuss in these different reflective contexts, are non-directive, it is up to the CoP teaching programme to address understandings of sex and related sexual attitudes.

Another related aspect of CoP's use of the self which impacts working with sexual issues is in relation to the therapeutic approach used. The increasing emphasis, particularly in CoP, on two-way, relational approaches to therapy that acknowledge how clients' are affected by their therapists' responses (Kahn, 1997; Lyons-Ruth, 1999; Stolorow & Atwood, 1997; Orbach, 2007; Rogers, 1957; Woolfe et al, 2010). This is particularly the case, in relational psychoanalysis (Lyons-Ruth, 1999; Orbach, 2007; Stolorow & Atwood, 1997) and in person-centred approaches (Kahn, 1997; Rogers, 1957). Furthermore, evidence also suggests that the client-therapist working alliance/therapeutic relationship may be more important than the therapeutic approach used (Luborsky et al, 2002; Orbach, 2007; Stiles et al, 2008; Wampold, Mondin and

Moody, 1997; Wampold, Minami, Baskin & Tierney, 2002; Whelton, 2004), which means that CoPs' lack of understanding or judgement of clients' sexual lives, could put the therapeutic relationship at risk.

2.5.3 Formative influences on sexual understandings

It has been acknowledged in the literature that pre-existing sexual attitudes can be carried into therapist training and professional practice. Rønnestad & Skovholt's (2001) qualitative study of 100 practitioner psychologists, found that child and adult life experiences, alongside professional guidance, contributed to general personal and professional development and practice. This section therefore focuses on understandings of sex and sexuality that were acquired prior to CoP training, in relation to their impact on client work. These include childhood and adolescent learning about sex, sexuality and the body. Therapists' earlier learning regarding sex, spans numerous influences, including: school education, peers, parents, the media and their own experiences. It has been found that adolescents and young people have received inconsistent sexual information from different sources. This is borne out by the British national sexual attitudes and lifestyle (NATSAL-1) survey (Wellings, Johnson, Wadsworth and Bradshaw, 1994) which found that amongst 16-24 year olds, 34% of men and 27.4% women aged 16-24, got their main sexual information from friends. A further 27.2% of men and 28.8% of women reported learning through school education. A gender gap was also revealed, with 26.9% of women and just 5% of men citing learning from parents. The diverging sources of information and the gender differences in the way sexual information was communicated, suggest that cultural differences have in various ways, persisted in the present. This means that in contemporary culture, CoPs' also have to be vigilant to their own sexual and gender assumptions.

The preceding paragraph highlights that gender differences need to be considered in understanding formative influences on therapists. The 'sexual double standard' (Crawford &

Popp, 2003; Holland et al, 2004; Lyons, Giordano, Manning & Longmore, 2011), stipulates that boys/girls and men/women are influenced by 'rigid' gendered roles in relation to sexual behaviour (Robinson, 2005). For example, Lyons et al (2011) highlight how, if a man has multiple sexual partners, it can be seen as socially acceptable, but if a woman does the same, it is deemed unacceptable and she may be labelled 'promiscuous'. The double standard alongside the objectification of women, by men, that Mulvey (1975) terms the 'male gaze', Robinson (2005) argues, has consequences for how children, and later, adults (and CoPs), understand their gender and express their sexuality, in relation to gender norms and their sense of masculinity and/or femininity. These messages about sexuality have implications for how adult CoPs may understand sexual relationships, as Holland et al's (2004) qualitative research with young people has identified. Holland et al (2004), found that ideas about who individuals can fall in love with/have sex with; whether individuals are allowed to feel good about sex or not; and their right to consent or refuse consent, can be shaped by these normative rules. This can create a climate where the inaccuracy of information creates confusion and uncertainty as to how, in differing ways, young people can negotiate their sexual lives (Holland et al, 2004) and these ideas can be taken into adulthood and into therapeutic practice (Rønnestad & Skovholt, 2001; 2003).

In addition to the social influences, parental sexual attitudes can affect CoPs confidence to talk about and embrace their sexuality. Parental struggles to communicate sexual information to their children before they become sexually active, illustrates another example of how possible future CoPs' may receive misinformed or distorted sexual information. Lerner (1976) illustrates, in a case study, how the lack of information (and visibility) about the vulva, as opposed to the vagina, can affect a young girl's concept of herself as a powerful being and that she then sees herself as less important in comparison to men, as an adult. This highlights the importance of teaching girls the correct anatomical terms for their genitalia (Lerner, 1976) and corresponds

with the contemporary critiques of Freudian theory referred to in 2.3 (Eichenbaum and Orbach, 1982; O'Connor and Ryan, 1993). Markovic (2012) also gives an example of how these messages (distorted or not) can start from a very young age, through a father's refusal to correct their six year old girl's impression that sex is painful, so that they are put off having sex when older. Evidence that parental awkwardness also occurs when children are older, is demonstrated by Lee's (2003) identification that girls' encounter maternal discomfort regarding conversations about menstruation, sex and the body. Although these are just a few examples, they illustrate the protectionist approach that many parents adopt in response to the fear of the sexualisation of children, as the next paragraph will illustrate.

How contemporary children receive sexual information, has also been raised as a cause for concern, in the more recent Bailey Review, on the sexualisation of children (Bailey, 2011). It particularly highlights parental worries about their children becoming sexual, too early, through sexualised media images or clothing that appears to turn children into mini sexual adults. Mobile phones, the internet and social media were also of concern, as these have changed how information, both sexual and non-sexual, is accessed (Attwood, 2006; Barker and Duschinsky, 2012; Ringrose, Gill, Livingstone, Harvey et al, 2012). Barker and Duschinsky (2012) and Heller and Johnson (2010) challenged the Bailey report's recommendations to limit forms of sexual imagery, in the media (in print and online), and in shops, as these limits imply an authoritarian stance that strives to hide sexuality. Instead, the authors propose that the parental instigation of open conversations about sex would allow children to embrace and have power over their own sexuality (Barker & Duschinsky, 2012; Heller & Johnson, 2010; Markovic, 2012). Garner (2012) also argues that less attention has been focused on how boys are socialised into particular ways of being sexual that can potentially be harmful not only to girls, but to boys, too. The aforementioned literature suggests that despite sexual information (including pornography) now being more readily available, open discussions do not always happen. This implies that sexual

conversations are not easy and suggests that CoPs and their clients may have difficulty in easily talking about sex.

The obvious place that one would expect future CoPs to receive reliable information about sex, that would stay with them when they leave school and enter adulthood, is in school settings. However, teaching teenagers' sex education at school has also been found to be challenging. Measor's (1996; 2004) qualitative studies suggest a gulf between what teenagers wanted to learn (and already knew) about sex and what educators thought these teenagers needed to know. Gender differences in sexual knowledge and understanding were also found to be prevalent. This highlights how misinformation and the sense of uncertainty could exacerbate pupils' disengagement from school sex education lessons. This implies that when CoPs start their training, although they will, most likely, have more sexual and life experience than when they left school, they will not all have the same level of sexual knowledge and a level of misinformation may be present.

Further issues in educating young people about sex can be found in the apparent barriers to accommodating culture, sexual orientation and disability. Mac an Ghaill's (1994) interviews with secondary schoolchildren identified that understanding variations in the understanding of sex, due to differing ethnicities, religions and cultural background were important in the context of sensitively delivering sex education. Involving parents & the wider community, especially when parents do not speak the same language, was also highlighted (Mac an Ghaill, 1994). The sexual needs of young disabled people have also traditionally, been excluded from sex education (Kim, 2011; Shakespeare et al, 1996), as have LGBT young people (Formby, 2011). The continuing prevalence of homophobic bullying in schools (Guasp, 2012), also communicates to young people of all sexualities, messages regarding 'acceptable' forms of masculinity and femininity and the acceptability or not, of non-normative forms of sexuality (Mac an Ghaill, 1994; 2007).

Religion has also been found to contribute to how sexuality and behaviour is discussed (Sheldon, 2001; Timmerman, 2006). These examples illustrate that sex educators need to be alert to the differing meanings sex and sexuality may have for different population groups and if these are neglected, those young people could feel alienated by the absence of information that feels relevant to them.

The influences above, can apply to both adult clients and CoPs and confirm Rønnestad & Skovholt's (2001; 2003) finding that individuals' learning about sex and sexuality, is likely to be taken into their adult lives and professional training. However, enhancing one's sexual information, is not necessarily equated with an openness in attitudes. Noland, Bass, Keathley and Miller's (2009) American comparison of changes in sexual knowledge and attitudes at the start and end of a course, by both general students (control group) and sexuality specific students, found that those who acquired sexuality specific knowledge (particularly in relation to same-sex sexual orientation and gender reassignment surgery) did not necessarily broaden their attitudes or understanding (Noland et al, 2009). The significance of therapists' unexamined sexual attitudes are highlighted through Ridley's (2006) identification that specialist sexual therapists are just as prone to these difficulties and assumptions. She illustrates this through an example of how an inexperienced heterosexual couples therapist, who had not examined her own attitudes, became very uncomfortable discussing a gay male couple's sex life, which led to the couple to subsequently discontinue therapy. Furthermore, Ridley (2006) argues that these particular psychosexual therapy trainees were not given enough time to explore their own sexual feelings, beliefs and assumptions and needed to consider the intersubjective impact of their ideas on both client and therapist. This appears to stress that trainee therapists including CoPs need to engage with the experience and meaning of particular phenomena and examine their own attitudes, rather than just having factual information regarding particular aspects of sex and sexuality.

Having established that sexual attitudes can affect how CoPs work with sexual issues, the following study attempts to illuminate the consequences of clashes in values and/or therapeutic goals, between clients and therapists, which could include sexual attitudes and approaches to working with sexual issues. Farnsworth and Callahan's (2013) study of four different client-clinician value conflicts, further emphasise the consequences of how unexamined therapist attitudes can be problematic for the therapeutic relationship and also suggest ways to tackle this. These conflicts include 'pre-emptive' value conflicts, where the client and therapist goals differ significantly enough that the practitioner cannot work with the client. 'Adjacent' conflicts include those where clients' attitudes may disagree with those of the practitioner. 'Operational' conflicts refer to when the client and practitioner agree on the goals, but differ on how they will be achieved. The fourth type of conflict is 'unarticulated'. These, potentially, are the most risky, as the practitioner may be aware of 'emotional discomfort', but have trouble identifying why. Farnsworth and Callahan (2013) recommend close supervision and exposure to the client's world so as to address issues in therapeutic engagement which, the authors differentiate from prejudice. The authors also acknowledge that unarticulated conflicts may also hold elements of the unknown, unconscious ways in which a practitioner is affected by a client. Furthermore, these unconscious processes may have consequences, particularly relating to the emergence of sexual feelings in therapy (as discussed in 2.5.4) and emphasise the need for trainee CoPs to be able to reflect of their experiences and effectively use supervision.

2.5.4 Sexual feelings in therapy

A more recent strand of focus in the literature has been the presence of sexual and/or erotic feelings, which are commonly experienced in the therapeutic context, by both clients and therapists and can present difficulties for both parties (Pope, Keith-Speigel & Tabachnick, 2006; Pope, Sonne & Greene, 2006; Pope & Tabachnick, 1993). The personal and intimate therapeutic

space can foster erotic and/or romantic feelings, whether non-sexual or sexual issues are being discussed (Martin, Godfrey, Meekums & Madill, 2011). CoPs need to be able to handle sexual attraction in the therapeutic context, skilfully and if managed wrong, carries the risk of violating the ‘therapeutic frame’, a boundaried space that facilitates clients’ to feel safe to share their feelings (Luca, 2004; Sills, 1997; Norris, Gutheil and Strasburger, 2003), as well as potential damage to the practitioner’s career. Violations can include sexualised/flirtatious comments, inappropriate physical contact, to kissing and/or sex with a client (Norris et al, 2003). These should be distinguished from boundary crossings, such as accidentally bumping into a client on the street, which, if discussed the next time client and therapist see other, no harm is done (Norris et al, 2003; Plaut, 2008). The implications of these erotic feelings apply to all therapeutic approaches that CoPs may utilise.

However, the challenges of identifying and working with clients’ erotic feelings has been discussed predominantly in the psychoanalytic/psychodynamic literature, in relation to transference and countertransference (Celenza, 2010a; 2010b; Jorstad, 2002; Marshall, 2010; Rouhalamin, 2007; Sherman, 2002) or in the context of therapist sexual feelings and boundaries of professional conduct (Baur, 1997; Martin et al, 2011; Ladany, Friedlander and Nelson, 2005; Norris et al, 2003; Plaut, 2008; Pope & Tabachnick, 1993; Pope, Keith-Spiegel & Tabachnick, 2006). These raise questions as to how different therapeutic approaches may consider the meaning of sexual responses and manage these in the therapeutic context, particularly given that CoPs all train integratively, with a degree of flexibility as to which therapeutic approaches they employ.

Of concern to date is that of the recent studies focused on supervision, little training has been provided to therapists in managing erotic feelings in therapy (Ladany et al, 1997; Ladany et al, 2005; Riessing & Di Giulio, 2010). Ladany et al (2005) found that trainees were dependent on the

skill of the supervisor in ascertaining issues related to sexual attraction, as trainees did not always disclose their sexual attraction. Less research focuses on the experience of trainees and much of the literature centres on sexual transgressions and their consequences (Baur, 1997; Gabbard and Hobday, 2012; Martin et al, 2011; Ladany et al, 2005; Norris, 2003; Plaut, 2008; Pope & Tabachnick, 1993; Pope, Keith-Spiegel & Tabachnick, 2006). However, limited research has been conducted on the prevalence of sexual transgressions, possibly due to the sensitive nature of the issue. Furthermore, none of this research has focused specifically on trainee/qualified CoPs, although, as CoPs do work in similar contexts, it is possible to infer that the experience of CoPs and their uncertainty in managing these situations, may be similar.

Within the few studies that have examined the prevalence of sexual violations, the studies suggest that sexual transgressions have around a 7% incident rate (Holroyd & Brodsky, 1977; Pope, Levenson & Schover, 1979). Pope and Tabachnick (1993) found that 27 of 285 participants stated that they had some kind of implied or actual sexual contact with clients, which included: client disrobing; sexual contact; discussing therapist sexual fantasies with the client and/or discussing having a sexual relationship with them on finishing therapy. These therapists also reported a higher rate of complaints against them. Pope, Keith-Spiegel & Tabachnick (2006) found that 95% of 339 men and 76% of 249 women have felt attracted to a client at some point during their work, with men reporting an increased rate of considering a sexual relationship with a client, although they did not act on it. 57% of therapists who had experienced attraction sought supervision. Younger therapists, particularly (possibly less experienced), were most likely to seek supervision, and felt ‘uncomfortable, anxious or guilty’ about these feelings. There was a trend for these ‘uncomfortable’ therapists, to feel that if their client(s) knew about their sexual feelings, it would be harmful to the therapeutic relationship. The above findings imply that sexual feelings were found to be very common and seemed to be accompanied by uncertainty as to how to manage them. Yet, there was some evidence that for a smaller minority of

practitioners, there may be temptation to breach those sexual boundaries (Pope et al, 2006). This raises the question as to how, specifically, CoPs handle sexual attraction that may occur in the context of therapy. The literature also highlights the need for all therapists, including CoPs, to have regular monitoring in their work and appropriate supervision.

A more recent study within the British Psychological Society on sexual contact, was aimed at clinical psychologists, a discipline closely associated with CoPs. Garrett (1998) found that fewer than 4% had engaged in sexual contact with their clients, either during or after clients had completed therapy. 22.7% of the psychologists who were surveyed had treated those who were previously involved with their therapists. Furthermore, when practitioners had sexual contact with supervisors during training, practitioners were more likely to make boundary transgressions with their own clients. This, again, highlights that boundary transgressions are common and that possibly there is doubt about what is appropriate behaviour, as a modelling effect of supervision is also indicated (Garrett, 1998). The effect of supervision in managing these feelings appears to be important, as does training. These above studies do not, however, explore the experiences of negotiating these feelings or how therapists may respond if a client feels attraction towards them, which is discussed more in the psychoanalytic literature, in the context of transference and countertransference (Celenza, 2010a; 2010b; Jorstad, 2002; Marshall, 2010; Mann, 1999; Rouhalamin, 2007; Sherman, 2002).

2.6 The relation of this literature to the proposed study

This section examines how the multiple knowledge bases and perspectives covered in the introduction and literature review have identified how CoPs could usefully apply therapeutic work in the context of sexual issues and considers the implications of these findings for the proposed study. Attempts to ascertain general trends in sexual activities and behaviour (Kinsey et al, 1948, 1953; Masters & Johnson, 1966; 1970; 1979; Masters et al, 1982; Wellings et al,

1994; Johnson, Mercer & Erens et al, 2001; Mercer et al, 2013) have focused on the general population. These findings have contributed to: challenging popular assumptions as to how sex 'should' be done (Bancroft, 2004; Goodwach, 2005); and assisted in identifying sexual behaviour that carries risk for sexual infections and reproductive health and the management thereof (Johnson et al, 2001; Wellings, Collumbien, Slaymaker et al, 2006). Therapist awareness of what people do sexually, can also help therapists work out how to approach sexual topics (Kaplan, 1995; Bancroft, 2009; Brewster & Wylie, 2008; Denman, 2004). Furthermore, attempts to discover what people think sex is, as opposed to what they do, revealed sexual presuppositions, by those who construct the questionnaires (Kinsey et al, 1948, 1953; Mercer et al, 2013; Sanders & Reinisch, 1999; Pitts & Rahman, 2001; Randall & Byers, 2003). The limited choice of sexual options in these questionnaires reduced the range of possibilities for what can be considered sex and may not accurately represent individuals' sexual lives. These findings also imply that CoPs and their clients may have very different ideas of what sex and sexuality are, which may cause confusion as to how to negotiate sexual discussions with clients.

The literature to date, also appears to suggest that what counts as a sexual issue, differs depending on the perspective taken. It could be argued that the biological, sociological and psychological perspectives all have elements that are potentially useful. Understanding the biological mechanisms of sexual acts, can play a role in demystifying sex, as a topic, both in society and when educating clients (Bancroft, 2009; Stevenson, 2010). However, the use of the DSM and ICD diagnostic categories reduces individuals' sexual issues into pathologies that have to be 'solved' and assumes that culture plays a minimal part in shaping the ways in which sex is thought of as normal or abnormal. This leaves little room for notions for 'healthy sexuality', as stipulated by the WHO (2006) definition (see 2.2) or for relating to a diversity of sexual practices and orientations (Barker, Bowes-Catton, Iantaffi et al, 2008; Barker, Iantaffi & Gupta, 2008; Barker & Langdridge, 2010; Davies, 1996).

In contrast, the symbolic interactionist perspectives (Simon & Gagnon, 2003; Plummer, 1995; 2003) challenged the biomedical perspective to consider how the norms and values associated with individuals' interpersonal, social, political and cultural contexts, impact on the construction and negotiation of sexual meanings and conduct in relation to themselves, other people and the world. This emphasises therapeutic practitioners' need to be alert to the impact of clients' personal sociocultural meanings of sex; and how these may differ from therapists' own assumptions about sex and/or sexuality. Whereas, poststructuralist perspectives go beyond symbolic interactionist ideas. They questioned assumptions as to what sex, gender and sexuality are and acknowledged forms of sexuality that go against the norm of heterosexuality, including sexual practices and relationship forms that are less visible (Foucault, 1981, 1986, 1988; Butler, 1990; Weeks, 2010; Barker & Langdridge, 2008; 2010). Symbolic interactionist and poststructuralist perspectives do acknowledge some of the influences on how a person's sexual identity is formed (Plummer, 2003; Simon & Gagnon, 2003; Robinson, 2005). However, these approaches do not take into account the experiential meaning that individuals give to sex and sexuality; and they do not further the understanding of how therapeutic practitioners experience their work with client sex and/or sexuality issues.

The approach to therapeutic work with sexual topics may have initially been influenced largely by the historical legacy of how sex has been viewed within biomedical, psychotherapeutic and mental health fields (Freud, 1900/1953a; Freud, 1905/1953b; 1923/1961; Pilgrim & Bentall, 1999; APA, 2000; 2013; Goodwach, 2005). Since, then, variations of a biopsychosocial approach have emerged (Denman, 2004) which include combinations of biological, psychological and social understanding of sex and sexuality, in relation to the therapeutic work.

The literature has also identified that therapists commonly encounter client sexual issues even when they do not specialise in them (Ford & Hendrick, 2003; Riessing & Di Giulio, 2010). The findings indicate that there is personal discomfort and uncertainty in dealing with sexual issues, particularly, given the minimal training on sexual topics (Ford & Hendrick, 2003; Harris & Hays, 2008; Parritt & O'Callaghan, 2000) and this does suggest a confrontation with therapists' own feelings, attitudes and values towards sex. Trainees in sex specific therapy have also been found to not necessarily be comfortable examining their own sexual attitudes and assumptions (Ridley, 2006). Investigations of therapists' understanding and experiences of working with sex/sexuality have mostly focused on quantitative research, of which, some of these scales include, historically: the sex knowledge and attitudes test (Miller & Lief, 1979); the sexual attitudes scale (Hudson, Murphy & Nurius, 1983); the multidimensionality of sexual attitudes scale (Hendrick & Hendrick, 1987) and latterly, the Ford & Hendrick (2003) and Harris & Hays' (2008) studies, cited in 1.2; the brief sexual attitudes scale (Hendrick, Hendrick & Reich, 2006); the NATSAL studies (Wellings et al, 1994; Mercer, Fenton, Johnson, Copas, et al, 2005; Mercer et al, 2013); Richters & Song (1999); Pitts & Rahman (2001); Randall & Byers (2003); Peterson & Muehlenhard (2007); and Horowitz & Spicer's (2013) studies. These studies have been found to have considerable researcher bias regarding what is understood to count as 'sex'.

As mentioned in 2.5.2, CoP stresses the importance of the use of and awareness of the self, within the therapeutic process. The minimum personal therapy requirement (40 hours) in CoP training emphasises the importance of self-examination and self-awareness (BPS, 2005; Orlans and Van Scoyoc, 2009) in order to use the self within the therapeutic relationship to effect client therapeutic change. However, there is no specific requirement that trainee or qualified CoPs must examine their own (including sexual) attitudes and feelings (Rizq, 2010). This raises the issue of how trainee and qualified CoPs, decide whether sex is an issue that warrants examination. Furthermore, although it has been identified that on clinical psychology courses,

there is wide variation in sex and/or sexuality teaching (Shaw, Butler & Marriot, 2007), no known research has examined specifically, how much training CoPs receive on sex and/or sexuality and what the consequences of this might be for dealing with sex and sexuality in the therapeutic space.

2.7 Rationale for this study

The reasons for exploring counselling psychologists' experiences of working with client sexual issues in therapy, are threefold. Firstly, while there has been research looking at other therapeutic practitioners' experiences of working with sexual topics, there is limited research available specifically on CoPs' experiences; the research that does exist on non-CoP therapist sexual attitudes and approach to working with sex and sexuality, as identified above, is imbued with considerable assumptions about sex, which challenges quantitative approaches' claims of objectivity (Willig, 2008).

Secondly, what emerged from the existing literature on working with sexual issues, are the difficulties practitioners' encounter, ranging from lack of confidence/comfort, to lack of knowledge and clashes with differing attitudes to sex (Ford & Hendrick, 2003; Harris & Hays, 2008; Stevenson, 2010). A practitioners' lack of awareness of their own attitudes and their impact on clients can mean sexual issues are not identified and/or, important aspects of a person's sexual life can be ignored/dismissed and/or seen as problematic when it need not necessarily be, for example if someone is not heterosexual and/or is polyamorous or asexual (Davies, 1996; BPS, 2012, Ridley, 2006; Riessing and Di Giulio, 2010).

Thirdly, if erotic feelings which emerge in the therapeutic process are unaddressed, these can have serious consequences for threatening the therapeutic alliance and/or transgressing boundaries and causing harm (Riessing & Di Giulio, 2010). Thus, as this literature review shows

the understanding of, and meanings of sex, for therapists and counselling psychologists in particular are problematic and important, as they can impact on their therapeutic work with clients and this research proposed to explore this.

2.8 Aims and objectives for the proposed research

From the above review, this research aims to address issues identified that are relevant to the counselling psychology literature, particularly relating to understandings and experiences of sex and sexuality in the therapeutic context. By adopting a qualitative methodology, employing an interpretative phenomenological analysis, it is hoped that a richer, more detailed account of CoP participants' understanding of sex will be identified in order to clarify the nuances of individual CoPs' experiences of working with clients' sexual issues.

The proposed research aims to explore counselling psychologists' understanding of sex and sexuality; to identify what has influenced these understandings; and explore how these understandings impact on counselling psychology practice. The outcome of these findings, it is hoped, will enhance understanding of how counselling psychology can embrace working with sex and related sexuality topics. It will also identify further training needs of counselling psychologists and add to the literature on the understanding of sex and sexuality. To this end, the proposed research question was: "How do counselling psychologists understand and experience working therapeutically with sex and sexuality?"

CHAPTER 3 METHODOLOGY AND METHOD

3.1 Overview of chapter

This chapter will address the methodological approach chosen and explain its ontological roots and the epistemology used to investigate and answer the research question: *"How do counselling psychologists understand and experience working therapeutically with sex and sexuality?"* It will also focus on the method used to recruit participants and collect interview data. Finally, the analytic steps employed will be outlined, which produced the findings reported in Chapter Four.

3.2 Choosing an analytical approach

This research aimed to explore how counselling psychologists understand and work with sex and sexuality in therapeutic contexts. Other methodologies were considered and will be briefly evaluated to argue for IPA being the chosen analytic approach. For example, a quantitative empirical approach (Barkham, 2003) could have been used to identify what attitudes to and knowledge about sex and sexuality, would usefully inform therapeutic work. However, as noted within the literature review (see 2.7) this research was more interested in a bottom up approach to capture *"…the 'quality and texture' of experience"* (Willig, 2008, p.8).

Some of the different qualitative research methods that were considered are also outlined here. One possible method of enquiry was a Foucauldian Discourse Analysis (FDA; Foucault, 1981; 1986; 1988). This could have explored two strands: Firstly, how CoPs' understanding of sex and sexuality, positions them, in relation to discursive power structures that permeate social, political and organisational contexts. Secondly, an FDA could have identified the dominant sexual norms which influence the dynamics between client and therapist. These sexual norms include for example, possible biases towards heteronormativity as identified by Rich (1980) and

Robinson (2005) and moral binary discourses of right/wrong or normal/perverse. Understanding these norms and power structures could help to clarify how sex is regulated in relation to the panoptical surveillance of the confessional self (Foucault, 1988). The aforementioned FDA investigations, although useful, were not adopted as they could not address the realities of individuals' personal feelings and experiences regarding their understandings and meanings of sex and sexuality, both personally and professionally, a consequence which may have real implications for therapeutic practice.

Grounded theory (Glaser and Strauss 1967; Strauss & Corbin, 1990; Charmaz 2006) was another possible method considered to address my research question. Grounded theory aims to generate a singular data-derived theory, by grouping data incorporating *"incidents, events and happenings"* (Corbin and Strauss, 1990, pp. 6), into conceptual categories. Relationships are then identified between these categories, to capture social processes that are theoretically associated with a core category. However, grounded theory was considered inappropriate for this research as its main aim is to produce a theory of social categories of meaning whereas the interests of this proposed research was to map out the key themes about sex and sexuality of relevance to Counselling Psychologists. Consequently, the decision to use an Interpretative Phenomenological Analysis was made.

3.3 INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS (IPA)

This section will cover the reasons why a qualitative IPA approach was chosen to address the research question above. It will also explain how IPA's philosophical and epistemological underpinnings, comprising of phenomenology, hermeneutics and idiography, are relevant to enhance an understanding of these participants' accounts.

Phenomenology

Interpretative phenomenological analysis (IPA) has its philosophical epistemological roots in phenomenology, with the emphasis on understanding the personal subjective 'lived experience' of a particular (idiographic) set of people, located in a specific context and seeks to understand these experiences from the participant perspective (Eatough & Smith, 2008). In the context of this research, this applies to counselling psychologists' perspectives on sex and sexuality. The phenomenological approach is captured in the following quote referenced from Husserl:

'To the things themselves' (Zu den Sachen) expresses the phenomenological intention to describe how the world is formed and experienced through conscious acts" (in Eatough & Smith, 2008, pp. 180).

The above quote refers to the process of consciously examining and reflecting on a particular experience, by which, one can learn more about it. By listening to understandings of sex and/or sexuality and how they are dealt with in the counselling room, one can become aware of the meanings attributed to the concepts and become closer to the experience of engaging with these concepts in the therapeutic space. Thus, for Husserl (in Smith, Flowers & Larkin, 2009), there is an 'intentionality' of relationship between the act of examining and reflecting on the particular experiences of bearing sex and sexuality in mind.

The awareness of the aforementioned process of examination and reflection can be linked to Heidegger's sense of 'being-in the-world, or 'Dasein' (in Eatough and Smith, 2008). By exploring how a person engages with and acts in the world, can enable an understanding of how a person is 'being there' in the moment, within a particular experience of a particular phenomenon. This concept of Dasein also applies to the researcher, who is an active participant in a lived world, of which, the researcher's experience of sex and sexuality may be similar or different to their

research participants. Therefore the sociocultural and historical context in which both the participants and researcher are situated, means that the researcher's analysis is inevitably one of many potential subjective interpretations (Willig, 2008). These interpretations are embedded in the discipline of hermeneutics, the theory of interpretation (Eatough & Smith, 2008), which acknowledges that steps must be taken to minimise the inevitably subjective nature of interpreting research data. (See hermeneutics and researcher's reflexivity for more on this).

Hermeneutics

Hermeneutics, the study of interpretation, is a central component of how IPA is understood. In attempting to phenomenologically enter another's world, a double hermeneutic is at play, whereby, the participants' attempt to make sense of sex and sexuality, in interview, is one interpretation. The researcher's attempt to interpret and make sense of this data, is the second interpretation (Smith, 2004; Shinebourne, 2011). The possibility of multiple layers of interpretation, necessitates a need for continual reflexivity by the researcher on the process of analysing the data and being aware of how the researcher's own understanding of sex and sexuality influences particular interpretations (Finlay and Gough, 2003). By acknowledging the researcher's influences and biases, regarding sex and sexuality, the research can attempt to 'bracket off' their own sexual assumptions, in an attempt to empathically enter another's world (Smith et al, 2009), a notion referred to as 'empathic hermeneutics' (Smith and Osborn, 2003). Simultaneously, the researcher also attempts to question how 'true' this interpreted world is, through a 'questioning hermeneutic' (Smith and Osborn, 2003) and the aim is to combine the two in order to, as closely as possible, give a true account of the participant's world, as far as is possible.

Idiography

IPA research is also idiographic, meaning it focuses on specific phenomena (sex and sexuality) as they exist, in a particular time, place and context (for example, qualified counselling psychologists, all interviewed around the same time). The aim of the research is to elicit depth of understanding which means that the sample size does not have to be large to obtain a qualitatively comprehensive understanding of an experience (Smith et al, 2009). The depth of understanding across individual participants can generate themes relating to a phenomenon that affects more than just the sample that are interviewed. Thus, results, to a limited extent, can be generalised to the group that these participants may also represent. However, this does require a homogeneous sample, particularly for studies such as this proposed research (Smith et al, 2009).

3.4 THE EPISTEMOLOGICAL STANCE OF IPA

Having chosen IPA as the research methodology, the ontological (how things are) roots of IPA and the epistemological (how we conceptualise what can be known) stance it takes to gathering knowledge (Crotty, 1998), need to be explained. This research is informed by a critical realist epistemology, which combines both interpretive and realist perspectives. 'Critical realism' (Willig, 1999 in Lawthom and Tindall, 2011) can be defined as: *'That [which] maintains a central focus on the ways in which people make meaning of their experience, whilst being aware of the influences that broader social structures have on those meanings'* (Lawthom and Tindall, 2011, pp. 9). This definition acknowledges that 'sex' and 'sexuality' are real concepts and the experiences related to them, both exist in the real world, whilst also acknowledging and critiquing how reported meanings associated with these phenomena, are mediated by the sociocultural context in which they originate (Lawthom and Tindall, 2011).

The assumption that sex and sexuality are real concepts, is in keeping with much positivist empirical research from medical and psychiatric perspectives on both sex and sexual dysfunction; and studies of sexual behaviour, such as the DSM-IV-TR (APA, 2000) and DSM-5 (APA, 2013) NATSAL-3 (Mercer et al, 2013), amongst others (see 2.7 for more studies). These highlight an ontology that assumes a fixed notion of what 'sex' and 'sexuality' are. Realist perspectives have been challenged by a more relativist ontology, that existence is relative to varying contexts. Epistemologies related to this stance, include interpretivist and constructivist epistemologies. Interpretivist ideas such as Plummer (2003) and Simon and Gagnon's (2003) sociological, symbolic interactionist theories, both assume that there are many different subjective viewpoints, which emerge from individuals' experiences, as to how sex and sexuality can be interpreted and understood. The realist and the constructivist combine to form a critical realist epistemology which takes account of both meaning and social context (Lawthom and Tindall, 2011).

By contrast poststructuralists extend the relativist perspective and view reality as unknowable due to the opacity of language understood as discourse. They would therefore question and deconstruct the essentialist basis of the realist position and argue that there are many discursive constructions of sex and sexuality that offer varied power-laden positions for individuals (Attwood, 2006; Butler, 1990, 1993; Foucault, 1981, 1985, 1988; Weeks, 2010). While the research focus of this study is not aimed at deconstructing the discursive production of sex and sexuality, rather, in keeping with the critical realist approach, it aims to acknowledge the possible real effects of particular meanings that participants' understandings illustrate.

Overall, the critical realist stance utilised by this research, it is argued, allows 'sex' and 'sexuality' to be discussed more meaningfully, to consider the possible effects of particular accounts for CoPs and the therapeutic profession more widely. The literature reviewed in Chapter Two has

identified that ‘sex’ and ‘sexuality’ are also understood as cultural phenomena that exist both ‘out there’ in society and within people’s lives. The meanings attributed to these concepts, may differ from person to person and a critical realist perspective seeks to understand and take account of these meanings and also critically examine the sociocultural context that contributes to them.

3.5 METHOD

This section will outline how the research study was operationalised, paying attention to ethics, participant recruitment, the interview procedure and steps conducted in the analysis of the data. See section 8 for related appendices.

3.5.1 Ethics

Due to the sensitive nature of this research topic the ethics application was carefully considered. Once ethical approval was obtained through the University of Roehampton Ethics Committee (appendix 8.1), the research was conducted in accordance with the British Psychological Society ethical research guidelines, to maximise benefit and minimise harm (BPS, 2011). Prior to interviews, the following were addressed in relation to ethics:

- Particular care was taken to ensure that participants understood the topic they were being asked to discuss, especially given the sensitive, personal nature of some of the questions being asked and the need for participants to ensure their clients’ confidentiality when discussing their client work in interviews.
- Participants were informed that all data would be held in a locked space, separately and confidentially from their identifying information. They were also told their interview recordings and their accompanying transcripts would be stored on a password protected computer.

- Any transcripts used in the write up would have identifying information removed or altered, to protect anonymity.
- A consent form was given prior to interview (appendix 8.4), including a further opportunity to ask questions and address any concerns they had.
- Participants were informed that at any point during the interview, they had the right to withdraw their consent and halt the interview, if they so wished and that their data would then be destroyed, to protect their privacy.

Post interview, a debrief sheet was given. In recognition of the sensitive nature of the topic and the potential for distress, information was given on what to do if anything should arise from the interview. An information resource pack was held in reserve, should participants require it (see appendix 8).

3.5.2 Participant recruitment and selection

Following ethical approval (appendix 8.1) recruitment requests (appendices 8.2 and 8.3) were sent to the email lists of the BPS Division of Counselling Psychology; the BPS Psychology of Sexualities; Pink Therapy; and poster advertisements were distributed in some (non NHS) counselling services that the researcher had contacts in; and through word of mouth. The advertisement gave a brief explanation of the research and invited interested parties to contact the researcher for further information, which was provided when potential participants responded to the research request. Information was given on length of interview and recruitment criteria.

The recruitment criteria stipulated that counselling psychologists should be qualified, as this was in keeping with IPA requirements for a homogenous sample (Smith et al, 2009). Participants also did not need to have formal training in working with sexual issues. Qualified counselling

psychologists were those with a minimum of three years post-qualification experience, as it was assumed that very recently qualified CoPs would be less likely to have much experience of working with sexual issues. One participant had two years post-qualification experience, but as she had experience of working with sexual issues, she was included in the research. The number of participants recruited was constrained by practical concerns over how many people it may be possible to recruit in the time available. 11 people contacted the researcher and 8 agreed to be interviewed. When potential participants contacted the researcher, further information about the research was provided and any questions were answered, before they agreed to an interview. Arrangements for a time and place to meet were then decided via email or phone.

3.5.3 Participants demographics

A demographics sheet was filled in prior to interview, to give background information (see Appendix 8.5), which asked about age, gender identity, ethnicity, sexuality, previous counselling training, their training up to that point, specific to sex, gender and sexuality; and their therapeutic approach. All identified as female and as British and/or European except one, who identified as British with a European/Asian ethnicity. All identified as heterosexual. All identified both their training and their practicing therapeutic approach as integrative. Participants were aged from their 30s to their 50s, with six participants in their 30s. Four were not religious, although 5 participants had grown up in religious environments (4 Catholic, 1 Mormon). Table 1 gives the participant demographics:

Table 1: Participant demographics

Age	Gender	Sexual Orientation	Culture/ Race/ Ethnicity	Religion	Year Qualified	Therapeutic Approach	Contexts worked in.
34	F	Heterosexual	British	None	2007	Psychodynamic	NHS/ Voluntary
40s	F	Heterosexual	White European	Catholic	2009	Person centred	NHS
32	F	Heterosexual	White British	None	2009	CBT	NHS/Private
33	F	Heterosexual	White European	Non-practicing Roman Catholic	2010	Existential	Private/ Voluntary
35	F	Heterosexual	British White	None but raised Catholic	2008	Primarily CBT now primarily psychodynamic	NHS/Private
50s	F	Heterosexual	British/Asian/ European	Not specified	2000	Integrative	NHS
34	F	Heterosexual	European	Buddhist, raised Catholic	2006	Integrative with CBT.	NHS
34	F	Mostly heterosexual	British	None, raised Mormon.	2007	Systemic/ narrative/ psychodynamic/ integrative	NHS/Private

3.5.4 Interview procedure

In line with the requirements of an IPA analysis, semi-structured interviews were conducted. This allowed for open questioning and exploration of the research topic. The emphasis was on the qualitative depth of understanding, rather than breadth, of the research topic. The results would not be representative of the population as a whole, although, to an extent some generalisations can be made (Smith et al, 2009). In accordance with the British Psychological Society (2011) ethical guidelines, any questions or concerns participants had before interview, were answered. A consent form was given prior to interview and debrief information was supplied after interview (appendix 8.7). A fuller debrief information pack was provided, if needed (appendix 8.8). A digital voice recorder was used for recording the interviews and a computer was used for transferring digital files to computer for listening. All interviews took place over the course of 5 months.

3.5.5 Interview schedule and pilot study

The questions for the interview schedule were designed to be general and then more specific, while still remaining open enough to not restrict participants' answers (Smith et al, 2009; Smith and Osborn, 2003). Prompts were available for when participants felt stuck. The interview schedule that was constructed was tested in a pilot study of two interviews (following ethical approval). This resulted in the sequence in which the questions were asked, being altered slightly. The pilot study also identified that some prompt questions had been left out of the original schedule and this was rectified. The final interview schedule (see appendix 8.6) covered the following areas:

- How interviewees understood key definitions, including 'counselling psychology', 'sex' and 'sexuality'.
- The role they considered 'sex' to have in therapy (if any).
- How participants have worked with sexual topics and their experience of that;
- Further training interviewees thought might be helpful, if any.

3.5.6 Data analysis

This section will explain how the research data was analysed to produce the results to the research question: "How do counselling psychologists understand and experience working therapeutically with sex and sexuality?" The analysis was guided by the steps outlined by Smith et al (2009) and Eatough and Smith (2008) as follows:

- The data from interviewees (which was separate from any identifying information) was transcribed with attention focused, not only on the words spoken, but the pauses,

laughter and other non-verbal cues, which were included in brackets. The transcripts were numbered to assist with easy reference to quotes.

- All transcripts were created in the form of Microsoft Word documents and the transcripts were listened to a few times after transcription, alongside the transcripts, to ensure accuracy of the transcript and to pay attention not just to the words, but to the tone of voice and the manner in which participants spoke, such as speed of voice or hesitations.

- The transcripts were then re-read, on a case by case basis and initial notifications, thoughts and ideas were noted. The aim, as cited in Smith et al (2009), was to stay close to the participants' phenomenological experiences by noting what seemed to be of key importance to each participant. Linked to this was the importance of noting non-verbal cues and how they linked with the content, such as whether pauses had any significance in the context of what they were saying. These notes were made on the right hand side of the page and an example is given in Table 2:

Table 2: Emerging themes

Emerging themes	Transcript	Initial themes
Power of personal influences, *parental/maternal taboo*? Feeling inhibited. *Learning* from personal experience. Retaliation/determination to have a different experience and give others a different experience – *break taboo.* *Modelling from SV transfers to modelling for people in own life and for clients.*	R: Yeah. What do you think has influenced your understanding of sex? Both formal and informal. So that could include things like sex education, training, supervision./I: Mm/Whereas informal, childhood experiences, parental and family influences, erm, obviously you pick the level that makes you feel comfortable/I: Yeah/to talk about that. I: Yeah. I think absolutely everything does. Erm, you know, I think, erm, (.4) I think that there's an enormous link with, erm, one's own experience. So I think I grew up in a family, erm, where I think there was a lot of discomfort around sex. That I had a mother who, erm, I think if anything sexual happened, erm, you know if something was on the TV or in the newspaper, erm, there would be a real kind of, erm, kind of anger, erm, I don't know whether it was embarrassment. To me it always seemed like anger and wanting to sort of put it away, you know, that there was no sense of, erm, it being normal or accepted or comfortable. You know, it was always something, erm, that, you know, we can't talk about this and, you know, it's a terrible thing and, erm, and I suppose it's... it's probably, erm, it's probably influenced me in wanting to be very different with people in my own life, erm, I'm very aware that, you know, if there's ever any like nudity on TV or anything like that that, erm, I'm very aware that... that I'm much more comfortable that actually it, erm, there isn't that same response. And so I hope that with clients it's the same. And that I've learned so much in supervision in the post that I... I think although there's theoretical knowledge, erm, in the actual therapeutic training, I feel as though my actual knowledge of the work probably began in the post and with the active client work and with supervision and, erm, you know, the role modelling.	Whole life impacts on sexual understanding. *Social elements?* Direct link with her own experiences – *Negative messages? Censorship. Scared, maybe?* Family – collective **discomfort –** *one person uncomfortable, entire family uncomfortable. Powerful influence.* *Unacceptable. Not* ***'normal'*** *Forbidden.* **'Put it away'. Embarrassment.** *Seems like shame?* *Anger spurs her to be different? with the people she cares about and in professional work.* *Striving to demonstrate comfort. Learning from experience.* Made me **want to be different.** *Experience can motivate person to change.* *Link between own experience and experience with clients.* Re-thought understanding through practical work, not so much formal training. **SV as role model**.

- On the left hand side of the page, attempts were made to identify possible themes and to see where themes overlapped at different points in the transcript. Continually relating the themes to the data allowed the researcher to check that the themes were not abstracted too far from the data. Having established the themes from one participant into clusters (see Table 3, below), the themes were examined to see what they have in common, or not, so they could be grouped together to form potential master themes.

Table 3: Initial cluster of some themes for one participant

Initial cluster of some themes for one participant	
Sex – not obvious. Crude An act. Not necessarily intercourse Between two people **Sexuality - orientation** Different types of orientation. **Sexuality - Expression** Self and others Act Dress Femininity Gentle **Seeking out information** Media Peers Non-existence of communication. **Empowerment – knowledge as confidence building.** Feminist literature Practical information Knowing terminology as freeing. Transformation of understanding.	**Uncertainty – present** Meanings – sex Meanings – sexuality. External locus of meaning. Confusion **Early background – Restrictive.** Heteronormative. Lack of exposure Naiveté Political context. Suppression Subversion. **Unknowing – past.** Menarche/periods Becoming sexual Femininity and sexuality Mysteriousness Fear Uncertainty Shame Guilt Struggle Not accepting Hiding Embarrassment Taboo

- The process was then repeated for the other cases until a full set of themes and clusters of themes were identified for all participants. Attempts were made to bracket themes from each case and attend to the specific content in the transcript of each individual participant, before then looking at any similarities or differences in themes across cases, to create master and subthemes. In interpreting these themes for the purpose of IPA, decisions then had to be made as to which of the themes more clearly illustrated the overall experience of the participants. An example of one final master theme is outlined in Table 4:

Table 4: Master Theme 1 and Subthemes

Master Theme 1
4.1 Sex and sexuality as taboo: Remembered accounts of their adolescence.
Subthemes
4.1.1 The silencing of sexuality: Past adolescent influences of family, peers and society. 4.1.2 The effect of sexism in relation to adolescent understandings of sexuality. 4.1.3 Awareness of their legacy of adolescence.

- An attempt was made, as far as was possible, within the analysis, to 'bracket off' my own biases (Morrow, 2005), when interpreting the data. However, as noted in my self-reflexivity (see 3.6), it is virtually impossible to remain entirely objective and the analysis presented here is inevitably subjective. Nonetheless, through outlining my critical self-

reflexivity, my own self-interview, sharing interpretations with supervisors and peers and by paying close attention to the participants' accounts, I have attempted to represent the participants' meanings and experiences as closely as possible, as outlined in the next chapter.

The saturation point or sufficiency of interpretation of the data (Morrow, 2005) was reached through a process of repeated immersion in the data, by listening to and re-reading the transcripts to identify the themes in a case by case process and the examination of the themes overall. Alongside this was a close attention to the maintenance of a journal noting thoughts, feelings, and potential biases that could affect the interpretation of the data. As with all qualitative analysis, it is possible to keep looking for new themes, however, a saturation point was reached when no new themes emerged. This was identified when the researcher realised that new words for themes appeared very similar in meaning (such as 'unknowing' and 'taboo'). At this point the broader master themes and subthemes were brought together in a coherent whole, to formalise the results chapter.

3.6 Researcher's reflexivity

The nature of IPA as a 'double hermeneutic' (Smith, 2004; Eatough & Smith, 2008), necessitates the importance of being reflexive as opposed to reflective (Smith et al, 2009; Brocki & Wearden, 2004). The distinction between reflection and reflexivity is outlined in the following quote:

'Reflection can be defined 'as thinking about' something else (an object). The process is a distanced one and takes place after the event. Reflexivity, in contrast, involves a more immediate, dynamic and continuing self-awareness.' (Finlay, 2003. pp. 108)

Reflexivity is therefore understood as an in-the-moment process of 'critical self-reflection', rather than a retrospective process, which facilitated a continual awareness of how both the researcher and the research were intersubjectively related (Finlay, 2003). To be reflexive, the researcher kept a research diary including thoughts, feelings and responses both personal and relating to the research and research process. This brought to awareness (as far as possible) the researcher's own biases and pre-judgments, which could then be acknowledged, addressed and bracketed, throughout the analytic process. This allowed the researcher to get closer to the participants reports, in order to present as accurate an account as possible. In order to address researcher reflexivity, the following section is written in the first person, to ensure clarity and accuracy of my own reflexivity.

My interest in this research has many strands. At the start of my counselling psychology training, I was not initially working in sex/sexuality specific counselling placements. In contrast to some of my peers, anecdotally, I appeared to get more clients with sex and/or sexuality related issues, or with health issues that impacted on sex. Although I had a level of self-taught sexual knowledge (including a good understanding of sexual anatomy and basic sexual functioning) and was relatively comfortable with client sexual discussions, I was aware of a knowledge gap. I had no

formal training specifically on sex (though, sexuality and transgender issues; erotic transference and countertransference; and sexual abuse/trauma, were covered on my course).

From a personal perspective, I have identified as non-heterosexual and non-heteronormative since my teenage years. As a woman, I see myself as a feminist, who believes passionately in the right to sexual self-autonomy. In my own life, I have also met medical professionals who have appeared distinctly uncomfortable discussing sex and sexual practices and who had a narrow view of what sex might be. This seemed to highlight, for me, the taboo, that even amongst medical professionals, who are trained to work with the body, there is discomfort. Furthermore, my own personal therapy with two therapists (at different times), has given me very different experiences of how sexual discussions occur. Consequently, both my personal and professional training experiences stirred my curiosity as to how counselling psychologists, who are also health professionals, might understand and work with sex and sexuality issues.

By the time I conducted my analysis, I was working in an LGBT placement and a sexual health clinic, which was increasing my knowledge. I had to separate my experiences of these from my participants' experiences and pay close attention as to how that may affect my interpretation of the data. I had to be careful not to pursue an agenda and stay with my participants' frame of reference in relation to their experiences. I was also aware that I was learning from what my participants had told me and that this was influencing how I myself worked with my clients.

The process of this research was, in effect, more than just a 'double hermeneutic' (Eatough & Smith, 2008), but a quadruple or 'double, double' hermeneutic. My participant accounts were one interpretation, my interpretation of their data was another, my learning from them was another level of interpretation and that then influenced how I interpreted the data, further. This raised the issue of whether it was problematic that a trainee with relatively little experience of

working with sexual issues was interpreting the data of more experienced CoPs. However, as the research uncovered, length of time as a counselling psychologist, did not necessarily reflect participants' experience or comfort with engaging in client sexual discussions. A more experienced practitioner may also have been more likely to have a particular view of how to work with sexual issues and I believe I was able to be more open to differing ways of working with these issues.

3.7 VALIDITY/QUALITY

The validity and quality criteria set out by Yardley (2000) and Morrow (2005), propose clear considerations to bear in mind when conducting qualitative research, to enhance the validity of qualitative research results. These criteria were applied to this study as follows:

3.7.1 Sensitivity to context

In line with the principles of the idiographic nature of IPA, a sample including only counselling psychologists, would enhance the possibility that variations in how sex and sexuality were understood; and any similarities and differences in these understandings, would still be representative of counselling psychology. Throughout the recruitment process, care was taken to ensure that all potential participants' were qualified and had a minimum of 3 years post-qualification experience. Although demographic details such age, gender and sexuality were not screened for as part of the recruitment process, all participants were mostly of a similar age, all were female and all identified as heterosexual or mostly heterosexual and were therefore, a homogeneous sample. Participants did vary in their levels of experience in working with sexual issues, but as this was relevant to the research question this was considered appropriate to the idiographic nature of an IPA study.

3.7.2 Commitment to rigour, transparency and coherence

To ensure the data was being interpreted effectively, attempts were made to clearly detail the research process, including participant selection and recruitment, the interview schedule and interview process and the analytic steps taken to interpret the data. Two pilot interviews were also conducted in order to iron out any problems with the interview process. During data analysis, considerable care was required to stay faithful to each of the transcripts, by continually going back to the original data and checking that the themes reflected were as close as possible to the participants' accounts of events referred to in the analysis. Attending talks and discussions on IPA, also helped to enhance my understanding of IPA and fed into the analytic process. The research supervisor also read the transcripts and this added another level of verification to the data analysis. The outlined analytic steps and the appendices providing details of the research process, also provide another level of transparency. All data relating to different stages of the research process, including correspondence with participants, has been retained for future reference. Opportunities were provided through the university, to present the research ideas and findings. This allowed fellow students to ask questions and give feedback on their observations regarding this research and this also acted as a peer review.

CHAPTER 4 RESULTS

This chapter presents an interpretative phenomenological analysis of 8 counselling psychology participants' accounts that addressed the research question: "How do CoPs understand and experience working therapeutically with sex and sexuality?". Three master themes were identified that highlight participants' awareness of their developing confidence in their understandings of sex and sexuality as they progressed from adolescence, into adulthood, training and their professional lives. These themes are illustrated in Table 5. All names used are pseudonyms.

Table 5: Master and Subthemes

Master Theme 1	Master Theme 2	Master Theme 3
4.1 Sex and sexuality as taboo: Remembered accounts of their adolescence.	**4.2 Freedom and challenges: Personal and professional encounters with sex/sexuality during training.**	**4.3 Varying degrees of confidence: Experiences as qualified practitioners.**
	Subthemes	
4.1.1 The silencing of sexuality: Past adolescent influences of family, peers and society. 4.1.2 The effect of sexism in relation to adolescent understandings of sexuality. 4.1.3 Awareness of the legacy of adolescence.	4.2.1 Personal experiences as freeing. 4.2.2 Trainee challenges of sexual topics in the therapy room. 4.2.3 Intimacy of sexual feelings as threatening: Further therapeutic challenges.	4.3.1 The elephant in the room: To ask or not to ask. 4.3.2 Diverse therapeutic contexts as sidelining and inhibiting sex talk. 4.3.3 Breaking taboos. 4.3.4 Confidence to challenge clients' sexual ideas. 4.3.5 Impact of the self in the therapeutic process: Confidence, openness and reflexivity.

Master Theme 1

4.1 Sex and sexuality as taboo: Remembered accounts of their adolescence

This master theme acknowledges participants' remembered adolescent experiences relating to sex and sexuality, from their present position as qualified practitioners. They seemed to critically reflect on the then circulating taboos and social norms and how these influenced their emergent adolescent understandings of sex and sexuality. These experiences were also related to their understanding of gender roles and the possible impact of this on their present work with clients.

4.1.1 The silencing of sexuality: Past adolescent influences of family, peers and society

Most participants in this study were broadly contemporaries, having experienced their adolescence in the 1980s-1990s. Sex was reported, at that time, as seeming unspeakable or taboo, by six out of eight participants, of which, five of these six interviewees had a particularly religious upbringing (4 Catholic, 1 Mormon). Hope and Beth seem to convey a sense of shame, discomfort and secrecy relating to societal taboos and illustrate this through their examples of the onset of menstruation:

"I grew up really having very limited knowledge of my body. I kind of freaked out when I got periods, I didn't really understand it. Erm, I found it actually kind of... I didn't... Nobody really... My mum gave me a book and there was a class in school but I didn't really know anything. I was terrified of boys and girls, had no... Didn't want to be gay" (Sarah, L99-103).

"... I know sort of getting periods is not necessarily, erm, erm, about sexuality but it is sort of about kind of your femininity and changes and, erm, and very lucky, I was very lucky with that because I was in a sort of camp, school camp, when the girls were talking about... about periods and I got a period there, and I wouldn't have known about it otherwise..." (Hope, L229-233).

Hope and Sarah's association of menstruation with sexual feelings suggested their recognition of the menarche as related to what Lee (2003) describes as, a key developmental milestone in becoming an adult sexual woman. Sex also appeared to be silently promoted as linked solely to heterosexual intercourse and reproduction alongside what Holland et al (2004) describe as the potential consequences for pregnancies, childrearing or abortions, while its significance as related to pleasure, seemed unspoken and/or ignored. Sarah's 'terrified' emerging sexual feelings also appeared to go against the norm and her resultant, but not uncommon (Davies, 1996) sexual identity confusion/conflict, could have been reinforced by the implied feelings of shame, discomfort and doubt.

Sarah's 'freaked out' and Hope's 'very lucky' (to receive information) responses to menstruation, also suggest that their practical knowledge of menstruation via books/parents/peers appeared insufficient to address their adolescent understandings and feelings about sex. The ambivalent societal attitudes to menstruation identified by Lee (2003) seemed to be evident in these participants' implicit difficulties in approaching sexual feelings and topics with their mothers. This is illustrated by two other participants' mothers' reactions to representations of sexuality in the media, which appeared to lead to a profound silencing of exploration and conversation about sex and the body:

"Erm, it's interesting once I had a magazine, it was called More and in it had position of the fortnight and I remember my mother found it. She went mad. Mad. Why've you got that in this... you know, where did you get it from? And I think these are really important because it conveys a panic, it conveys an anxiety about something that actually is a very natural act" (Lucy, L322-326).

"That I had a mother who, erm, I think if anything sexual happened, erm, you know if something was on the TV or in the newspaper, erm, there would be a real kind of, erm, kind of anger, erm, I don't know whether it was embarrassment. To me it always seemed like anger and wanting to sort of put it away, you know, that there was no sense of, erm, it being normal or accepted or comfortable. You know, it was always something, erm, that, you know, we can't talk about this and, you know, it's a terrible thing" (Jen, L146-152).

These experiences highlight these participants' awareness of their struggle to negotiate sexual understandings within the sociocultural context of the time. The then circulating sexual ideas presented in the media, indicated a more open, permissive view of sex, which participants' appeared to play against their mothers' attempts to 'put away' or control representations of sex or sexuality. Their mothers' messages that sex was not 'normal, accepted or comfortable' and must be hidden or rendered invisible, seemed to provoke what Lucy described as a profound fear and 'anxiety' that seemed to be internalised and also stifled these participants' exploration of their sexuality. Participants' critique of their adolescent influences, also indicates their current awareness that alternative ways of thinking about sex, are possible. Additionally, these accounts illuminate the cultural gulf between parents and children as highlighted by Markovic (2012) in relation to sexual discussions, in this case, in terms of age (Lucy and Jen) and religion (Lucy), in perpetuating the conflict between the participants and their mothers.

In their adolescence, this sense of enforced silence seemed to encourage participants to look to peers to gain information. However, outside of limited discussions about menstruation, there appeared to be an absence of conversation about sex amongst peers. Hope and Sarah recalled that conversations about sex, with peers:

"wasn't existent" and minimally consisted of *"in-between sentences and words sometimes with other... with other children, but, erm, not in a kind of full... any full conversation"* (Hope, L236-238).

"[I] just wanted more knowledge and more understanding and then started to get brave and have conversations with other people. Erm, and then realising more and more that people didn't really talk about those things either. So it wasn't just me that wasn't talking about it, it was lots of other people aren't talking about it" (Sarah, L115-119).

The quotes indicate that the taboos surrounding sex, were not restricted to family and peer groups. Sarah's adult experience, of discussing sexual topics, reflected her realisation that the taboo around sex as she grew up, had a society-wide influence. Lucy, in contrast to other participants, seemed to be able to go beyond her family and use the conversations with her peers to counter her parents' sexual attitudes:

"...friends, peers have a massive impact. I think in some ways what made me looser to it [sex] was the fact that my friends were very open about it" (Lucy, L342-343).

Lucy's alternative account highlights that not all participants had the same experience. Although the silencing of sexuality appeared to have powerful effects, it was, to some extent mediated by other sources of information. Participants also indicated their awareness of how wider social norms and taboos influenced their teenage understandings of sex, which was reflected explicitly, in the following accounts:

"...I come from a (...) restricted Catholic background, where there was no sort of no conversation about sexuality or sex at all (...) I think, erm, the whole idea about sex and sexuality was a complete mystery to me, I think, 'til later on in life" (Hope, L207-209 & L216-217).

"I guess it [sex] comes originally from a place where it had a lot of meaning and also a lot of consequences, that you really had to be very careful and that it wasn't really okay if you're a teenager, you know (...) the pharmacist would look at you like, you know, why are you buying these, you are clearly not married, you are clearly too young to be having sex and you would feel this kind of feeling. So you see these, you know, young adults who are very embarrassed and kind of picking up the, you know [condom], and throwing it on the counter and looking away and feeling very embarrassed" (Beth, L116-125).

These extracts suggest a strong implicit sense of societal messages that sex and its expression, were taboo. Hope gives the impression that until she reached adulthood, there was no sexual conversation, in the media, wider society or her family. By contrast, Beth indicates in the attempt to buy condoms, a strong sense of embarrassment and fear generated by the anticipated judgment by others, of potential sexual transgressions by her and her peers. These experiences could be explained by Hope and Beth's upbringing in Catholic countries where religion appeared dominant in both society and the family. The implicit fear of the consequences of any expression of sexuality was also reinforced by the normative expectations regarding sex and relationships as:

"Romantic and traditional" [and that one] "should be a virgin and wait until marriage" (Beth, L112-113). These rules also led to feelings of: *"shame"* and *"guilt, that comes from the religion, relating to sex before marriage"* (Hope, L253-255).

These accounts may be understood as referencing an older generational structure that was influential during their adolescence, which seemed to suggest that 'traditional' social rules of conduct, must be adhered to. Sex seemed to be the preserve of only heterosexual, monogamous, married couples and any detraction from these norms seemed to be regulated by 'shame' and 'guilt' (Hope). Timmerman (2001) and Sheldon (2006) support this finding, particularly highlighting that the ways in which religion is taught can have a profound effect on how individuals view their sexuality.

4.1.2 The effect of sexism in relation to adolescent understandings of sexuality

This subtheme captures five out of eight participants recognition of the effects of their fathers/siblings and male peers "sexist" (Lucy, L330) behaviour towards them, in adolescence and how these contributed to their understanding of their own sexuality at the time. Sexism or sexist behaviour (as defined in 1.2) can be understood as the implicit and/or explicit systematic discrimination of women (Bates, 2014). These interviewees seemed to identify men's implicit and explicit knowledge of the power of women's sexuality and that men communicated messages that female sexuality should be controlled/stifled and/or forbidden:

"My dad was quite a sexist man and I think, you know, there was definitely a period in my life where I expressed my sexuality in quite a tomboy way (...) There's a sense, I suppose, [of] what I was trying to communicate to men is don't exploit me, don't use me. I'm not going to be sexy because if I'm sexy you'll get one up over me in some way" (Lucy, L329-335).

"... I grew up somewhere where saying no to a guy on the dance floor didn't make much difference but if your boyfriend turned up he would apologise and say "I'm very sorry, I didn't realise you were with someone. I mean it's fucked up [laughing]. It's really fucked up" (Kate, L620-623).

Lucy appeared to see her teenage understanding of her sexuality as partly influenced by her father's 'sexist' beliefs. She highlighted her awareness of the *"difference between my brothers and myself"* (Lucy, L271) in the way she was treated by her father. Lucy's reflections on her father's *"anxiety"* (Lucy, L274) that if she became pregnant, *"no man would possibly want you"* (Lucy, L275-276), implied his fear of Lucy's own sexual power, to attract another and feel attractive in her own social world. This fear appeared to be internalised by Lucy, as demonstrated by her dressing as a 'tomboy' to ward off the perceived threat of 'exploit[ation]'. This example also implies that her father communicated messages that men were not to be trusted either.

Similarly, Kate's use of "fucked up", in the extract above, appears to highlight her sense of anger at the hypocrisy of the 'double standards' (Crawford & Popp, 2003; Holland, 2004; Lyons, Giordano, Manning & Longmore, 2011) that differing rules for men and women regarding sexual expression and consent, meant relatively less power, respect and rights for girls/women. This appeared to be felt acutely by four participants, within their families and in society. This is crystallised by Sarah's adult reflection on this:

"There's also something about [that] male... maleness and sexuality only counts and that's really powerful (...) women don't really have a sexuality unless a penis is involved" (Sarah, L711-712 & 716-717).

Participants' appeared to recognise, in hindsight, how societal assumptions about gender roles and female sexuality, and in particular, the male gaze (Mulvey, 1975), shaped their early views of their sexuality. As Mulvey (1975) notes, regardless of how a woman sees herself, she is still perceived as a sexual object by men, rather than as a woman in her own right, with her own

sexual thoughts, desires and feelings. This seemed to be an ongoing struggle for these participants to disentangle from and led to two participants' explicit references to feminism, in helping them rethink their adolescent sexist assumptions regarding sexuality:

"I've read (...) [a] mixture between the kind of feminist and sort of a female sexual liberation type, erm, type of literature. It's very interesting, er, and enlightening as well. (..) not really for sexuality but (...) for cultural differences and how women are, erm, erm, you know, the subtleties of... of difference in the culture and, erm, what that means, I think, that was really interesting for me. But sexuality's part of that" (Hope, L299-301).

"...most of the stuff that women brought to me was about what does it mean if I have sex at such at such a point and how do I negotiate when I have sex, I mean, you know, that's stuff that really I had some very bad lessons on at school [laughing] and otherwise I mostly learnt about via the feminist community, erm, and through stuff completely outside of work" (Kate, L400-405).

Participants' adult engagement with feminist ideas appeared to help them re-evaluate their adolescent ideas about sex, sexuality, gender, relationships and their societal status as women. These female participants' questioning of gender seems to reflect Butler's (1990) notion that gender roles are 'performed' in relation to assumed expectations of gender appropriate conduct. Hope appears to find meaning in understanding how cultural differences in perceptions of women in society, can impact on sexuality. Whereas Kate's account of 'very bad lessons' at school, seems to imply, as Measor (1996; 2004) identifies, that school sex/relationship education omitted education on her rights as a woman, to negotiate her sexual and relationship boundaries, including whether, when and/or how to have sex. Kate suggests that had she not re-evaluated these ideas, via feminist input, that she may have thought an abusive (sexual or non-sexual) situation for a client, was the norm, a situation that could be detrimental for a client.

4.1.3 Awareness of the legacy of adolescence

This subtheme focuses on six participants' awareness, as adults, of the effect of societal taboos (4.1.1) and the implicit and explicit sexist messages regarding female sexuality (4.1.2), communicated during their adolescence. Participants' retrospectively reported their teenage understanding of sex as associated with:

"discomfort" and *"embarrassment"* (Jen, P5, L145-149); *"dirty and exploitative and gets you into trouble"* (Lucy, L289-290); *"shame"* (Jen, L302), *"anxiety"*, (Lucy, L274) *"guilt"* (Hope, L254; Jen, L255); and *"mystery, fear, not knowing"* (Hope, P2, L249) and *"taboo"* (Beth, Jen, Hope, Fran, Lucy, Sarah). These descriptors convey a sense of confusion and unease surrounding sex that suggested that sexual taboos persisted into early adulthood. This was reflected in participants' struggle to make sense of sex and led to four participants, reporting, in their late teens or early twenties, as having: *"...lost my virginity"* (Sarah, L110) *"quite late"* (Fran, L160) or *"quite a lot later to my kind of cultural or peer group"* (Lucy, L279).

As noted in Chapter Two, Peterson & Muehlenhard (2007) identified virginity as having a high sociocultural status. These participants recognised the influences of this cultural expectation on their perceptions of their 'late' 'loss of virginity'. Most participants appeared to confidently reflect on and identify their earlier struggles to understand sex and sexuality for themselves, whereas Hope's struggle to come to terms with her sexuality was ongoing:

"But, erm, erm, I think accepting it fully as part of me as... as... as a woman I think that is still not, erm, not as, you know, I'll say oh, I like cakes, you know, it's not the same level of in... erm, erm, acceptance, I think. Erm, there's... there's still a level of hiding and a lev... level of, erm,

embarrassment around it. Although not as high as it was when I was sort of end of, erm, sort of in my twenties or, you know, in my teens" (Hope, L262-267).

Hope's move to the UK, permitted her to discuss sex more freely than in her country of origin, yet, her sexual desire was still shrouded in 'embarrassment' and 'hiding', which seems to refer to the religious guilt (Timmerman, 2001; Sheldon, 2006) she mentioned earlier in 4.1.1. As an adult, she appears to struggle between her intellectual versus emotional understanding that sexual conversations could be as acceptable as discussing 'cakes'. Her hesitation, throughout this extract, reinforced the sense that at a deeper level it was harder to shift years of shame, guilt and discomfort in her own sexuality. None of the other participants cited such a marked level of struggle, although, it seemed to be implied to lesser degrees, through their later experiences as adults, both personally and professionally (see master themes 2 & 3). It is, however, interesting to note, that overall, the two participants who were not raised in a 'strict' or 'religious' background (Kate and Sophie), made minimal reference to earlier personal influences on their understanding of sex. This could possibly be because sex was less of an issue for them, as information was more readily available.

To conclude, the above subthemes in this master theme have highlighted how six of the eight interviewees had reflected on their reported earlier "struggle" to reconcile their past experiences with the then dominant circulating sexual norms and how these have impacted on them personally, in the present. The literature review also supports the participants' accounts of unhelpful or missing sexual information during adolescence (Wellings et al, 1994; Holland et al, 2004; Lerner, 1976; Lee, 2003; Garner, 2012; Markovic, 2012; Attwood, 2006; Barker and Duschinsky, 2012; Ringrose et al, 2012) and the impact of this on their sexuality as adolescents/young adults. Participants' levels of internal and external fear and judgment as adolescents appeared to create barriers to the freedom and permission to explore and negotiate

their own sexuality. These barriers to sexual exploration also impacted on how they saw their own sexual selves and where they wanted to be, in relation to the sociocultural norms that rendered sex as taboo and invisible. These participants' vivid accounts of adolescence, seemed to suggest that the impact of constraining sexual influences, to a greater or lesser extent, appeared to persist into adulthood, both personally and professionally. This will be expanded on in the next two master themes.

Master Theme 2

4.2 Freedom and challenges: Personal and professional encounters with sex/sexuality during training

This master theme focuses on participants' accounts of their exposure to experiences of sex and sexuality as adults, both personal and professional, prior to and during training, that firstly, allowed them to re-evaluate their previous sexual understandings and secondly, to develop their confidence in working with sexual issues in therapeutic practice. The first subtheme focuses on personal experiences that freed participants from earlier adolescent constraints, to embrace their sexuality. The following two subthemes focus on different aspects of participants facing challenges to sexual understanding, while in training and working with clients in placements. Overall, this master theme illustrates how participants encountered experiences that facilitated them to consider new ways of thinking about and working with sex and sexuality, in both their personal and training contexts.

4.2.1 Personal experiences as freeing

This subtheme identifies how five participants' talked about their sexual ideas and experiences in early adulthood that challenged old assumptions and gave them permission to question the previous influence of their family and societal norms. Fran and Beth's extracts focus on this exposure to new sexual ideas and experiences:

"I thought, you know, from not being introduced to it and being a bit scared of it [sex] to having this beautiful experience, I just thought, yeah, this is... this is good" (Fran, L163-165).

"Erm, this is also, you know, [the] contribution of the usual sort of media and magazines, in films and kind of what you learn from that [what] is acceptable and what is, you know, again, quite a different view (...) from where I'm from that, you know, sex is just something you do (...) it

doesn't really have to have a lot of meaning, it's just, you know, it might lead to a relationship, it might not; it might just be fun, it might be good, it might be bad, but it's kind of more flexible depending on how things turn out with it" (Beth, L129-135) .

Fran and Beth, as adults, away from environments that reinforced their previously restrictive background, could see the contrast between their experiences in their Catholic home countries and as young adults in the UK. This led them to question their own sexual understandings, illustrated by what appeared to be Fran's experimental retaliation against old norms, by going *"crazy"* (Fran, L170) and having sex with a succession of people; and Beth's freedom from past *"embarrassed"* or *"judge[ing]"* (Beth, L125-126) feelings, to reassess what she wanted for herself as a sexual adult. Whereas, Sophie, who grew up in the UK, said that in addition to personal sexual experiences, she gained knowledge and understanding about sex through:

"...*my own experience of sex and my own, erm, relationships that I've had"* (Sophie, L146-147) and through: "... *conversations you have socially, erm, I guess with friends, erm, you hear about people's experiences, erm, people's preferences*" (Sophie, L147-150).

Sophie's exposure to the 'experiences' and 'preferences' of others, seemed to enable her to make sense of the variations in how people conducted themselves, via sexual experiences and in relationships. Such experiences are also reflected by three participants' various references to interactions with other people, the media and literature in re-evaluating their sexual understanding.

Furthermore, while in training, the value of personal therapy was indicated by two participants, in permitting the exploration and understanding of their feelings and attitudes about sex and embracing their own sexuality. Lucy said that alongside supervision, therapy was *"key"* (Lucy,

L359) in developing her confidence to broach sexual issues in herself and others. Lucy and Jen reported therapy as:

"...very much learning experiences as well of, erm, seeing that women and sex could be something relaxed, something comfortable, something educational (...) [and not] just sort of put away or disapproved of" (Jen, L163-166).

"I think through my own therapy (…) I think that clearly [sex] it's come up 'cause it's part of life, you know, and... and to some degree I kind of understood that religion was a massive thing" (Lucy, L305-306).

These participants imply that, as identified by Sills (1997) and Luca (2004), personal therapy provides a safe, confidential, non-judgmental space. This allowed them to acknowledge the influential magnitude of past prevailing norms. Lucy highlights the 'massive' significance of her Catholic upbringing, which points to her earlier, implied (in 1.1. and 1.2; as identified by Sheldon, 2006), sexual shame and guilt. The role of personal therapy in questioning and disarming taboos, led Lucy and Jen to work through their internalised shame, to reframe sex, their own bodies and sexuality, as something positive and comfortable. Lucy also highlights the impact of personal therapy on client work, in the following quote:

"I think, as a psychologist or counselling psychologist (...), you have to be aware of what is going on for you, to see where you can go and where you can't go. 'Cause you ain't going to be able to go there for your client if you can't think about it [sex] yourself" (Lucy, L337-340)

The necessity for self-awareness and its importance for the therapeutic relationship (Celenza, 2010a, 2010b; Pope & Tabachnick, 1993; Pope, Keith-Spiegel & Tabachnick, 2006; Rønnestad &

Skovholt, 2001; Rouhalamin, 2007) is stressed here. As identified in the literature and noted by these participants, a lack of sexual self-awareness and practitioner discomfort in approaching sexual issues, could potentially hinder therapeutic work and/or, have harmful consequences for the client-practitioner relationship. However, as only two participants mentioned the role of personal therapy in relation to sexual understanding, it could be inferred that sex was not of utmost importance for all.

4.2.2 Trainee challenges of sexual topics in the therapy room

This subtheme focuses on two participants' experiences as of client work, as trainee counselling psychologists, that challenged their attitudes to working with sexual topics. Kate highlighted her discomfort in discussing sex with clients:

"... both me and my supervisor were much more ready to bring that [age & ethnicity] into the room and kind of just go so, is this an issue, [than] if the client made any kind of inclination that I think either of us were to kind of push a sex issue if... if we felt like it was there. And I don't know whether that's a cultural thing or just a me and her thing or whether people are just really risk averse about sex" (Kate, L408-415).

Kate's anxiety seems to echo the taboo surrounding sexual discussion, referred to in 4.1.1 - 4.1.3. Her greater comfort in addressing the impact of differences in cultural expectations relating to 'age and ethnicity', than sex, implied a comfort hierarchy as to which topics were regarded as more approachable. Kate's supervisor's uncertainty seemed to exacerbate Kate's discomfort, which suggests that Kate saw her supervisor as a guide to practice. Kate's confusion as to whether the discomfort belonged to her, or her and her supervisor, reflected her implied concern as to whether she was complicit in supporting the taboo norms and expectations of clients/supervisors/society. This also highlights the complexity of the interpersonal power

dynamics being enacted between client, trainee CoP and the supervisor, a dynamic linked to the intersectionality of different social categories and identities (Bhugra & Wright, 2004; Riggs & das Nair, 2012). Kate appeared to recognise that addressing sexual topics was important and her awkwardness at the time, reflected all participants' recognition of the need for further training:

"I think probably we can't assume that everybody had really good PSE [personal and social education] lessons at school./R: Hm-mm./So, honestly, I... I think, you know, PSE lessons for psychologists would probably be a really good plan. Erm, I think also, erm, some level of cultural awareness about sex" (Kate, L405-408).

Kate highlights that sexual understanding and competence when working with clients cannot be assumed and that there can be wide variation in what individual trainee CoPs know about sex and how comfortable they are. In contrast, the challenge of sexual conversations, were very directly confronted by Beth's exposure to her gay male clients' openness about their casual sexual activity and reported that "*[sex] took on a quite a different meaning"* (Beth, L138). She reflected on her response to her clients:

"Erm, you know, I wasn't exactly a prude but it did come as a shock. I was like my God! These men really have sex! Phww! [Laughing] I never knew this world existed! It's like where have I been living? Do normal people know this is really out there? Am I the only person who didn't know this was going on?" (Beth, L211-215)

Beth's 'shock' over this unknown sexual world, suggested a degree of naivety about sexual possibilities that contrasted with her normative ideas of what sex should be. She seems to convey incredulity, giving the impression that, at the time, she saw casual sex as possibly abnormal or morally wrong, hence her reference to looking towards 'normal people' to validate

casual sex as acceptable. It is also possible that homophobia (Davies, 2000) may have contributed to this view. However, I got the impression, through the tone of the interview and that as she had chosen to work with gay men, that casual sex was more of an issue, than her clients' being gay. This situation seems to correspond to Farnsworth and Callahan's (2013) 'adjacent' client-clinician value conflict, where therapist attitudes differ from clients, although the therapeutic goals are the same. Beth's search to understand her clients' worlds, seemed to allow her to resolve the conflict by using the information she gained, to re-evaluate her meanings of sex and the kind of sex she herself wanted (this process of re-evaluation was similar to her earlier response to the impact of media messages in 4.2.1). This seemed to enable her to gain confidence in her own sexuality, as well as transform her attitude to clients:

"...all of those [client experiences] played a part and kind of changed what my understanding of it [sex] is in what I find acceptable for myself (...) seeing that there are lots and lots of possibilities out there and that you can choose from all of these" (Beth, L156-157 & 161-162).

Beth and Kate's examples also illustrate support for Rønnestad & Skovholt's (2001) idea that both personal and professional worlds collide in the process of encountering sexual topics in therapy and directly impact on the CoP's self (see Section 2.5.2). Simon and Gagnon's (2003) sexual script theory also offers an alternative explanation for how these participants could resolve the conflict between social and personal sexual scripts, by using 'intrapsychic' scripts to re-evaluate the alternative views of sex and/or sexuality being presented to them (the social scripts, related to the perceived social rules of sexual conduct) in relation to their personal assumptions about sex and sexuality (their self-scripts), in both their personal and professional lives.

4.2.3 Intimacy of sexual feelings as threatening: Further therapeutic challenges

This subtheme captures four participants' uncomfortable confrontation with the experience of erotic feelings in the therapeutic process, both towards or from clients, during CoP training; and how supervision helped participants to manage these experiences and feel more comfortable. Baur (1997) has highlighted that the therapeutic situation can foster what these participants described as 'intimacy' (whether they were discussing sex or not), which led to the development of sexual attraction, an experience that seemed unexpected, as Kate and Jen realised below:

"I remember being really disconcerted to find myself having sexual feelings at all in a therapy situation. Erm, and particularly 'cause she was a woman, so I was like that makes no sense" (Kate, L317-319).

"I think there was a kind of a mutual attraction [...] there was a great deal of intimacy and connection there.[...] and also, erm, (.2) a kind of an invitation to be drawn into, erm, a non-therapeutic relationship" (Jen, L251-255).

Kate's 'disconcerting' feelings could be explained as due to the threat these feelings posed to her heterosexual identity. In contrast, Jen's temptation to deepen the intimacy between her and her client and breach the 'non-therapeutic' ethical boundaries, she knew, risked destroying the therapeutic relationship (and by implication, her career). These participants, in contrasting ways, appeared to face confusion and uncertainty in managing these sexual feelings, a finding echoed in the literature (Celenza, 2010a, 2010b; Ladany, Friedlander and Nelson, 2005; Rouhalamin, 2007). Both participants turned to their supervisors for guidance, as Kate illustrates that she *"mostly ignored it [the feelings] completely and then took it to my supervisor"* (Kate, L324). She linked her uncertainty and avoidance of sexual attraction to her previous work in an adolescent ward where she *"got quite used to kind of checking my sexuality at the door and then picking it*

up on my way out" (Kate, L313-314). It was as if Kate denied ownership of her sexual feelings, until confronted with them and used her supervisor as a means to defuse them.

Sarah, Jen and Lucy also acknowledged that the *"trust"* (Sarah, L400), *"intimacy and connection"* (Jen, L254) engendered by the personal nature of the therapeutic relationship, seemed inevitable and inescapably personal:

"...that it can become about you and the work that you're doing" (Lucy, L251).

"I think there's a very strong intimacy that happens when you talk about these things with people. There's a lot of trust. (...) it raises all the things that all relationships raise in terms of, erm... All of a sudden I want to call it like transference and countertransference. But it just raises all the issues that having relationships with people raise and that kind of, erm, being a part of something, not being a part of something; the importance of boundaries" (Sarah, L399-404).

Sarah's reference to the psychodynamic processes of transference and countertransference (Lemma, 2003) suggests that she used psychotherapeutic theory to understand her personal experience in relation to clients; that what transpires in the therapeutic relationship, is embedded with meaning and consequences that go beyond the therapy room and permeate both the client and practitioner's 'real' worlds. This is illustrated through the client Kate had earlier stated her attraction to, who said to Kate in the following session, that she *"just wanted sex"* (Kate, L334). To Kate's relief, her own sexual feelings disappeared. Picking up on her client's sexual feelings however, left her confused as her countertransferential feelings extended into her own world outside the therapy room. Although Kate did not label this process in theoretical terms, she had prior to interview, confirmed that she works psychodynamically and her account makes sense of this.

The awareness of the consequences of sexual transgressions with clients was indicated by three participants' acknowledged need to gain *"clarity and correctness"* (Jen, L257) or *"channel it [sexual feelings] into the right place"* (Sarah, L449). This suggested an inherent ethical and moral value to therapy, as professional guidelines stipulate, to do no harm to the client (Bond, 2009; BPS, 2009). Thus, by utilising theory, participants' feelings were disentangled from the personal and ethical aspects of the therapeutic process and *"given back"* (Jen, L35-36) to the client.

By contrast, Lucy's difficult experience on her training placement, gave an example of poor supervisory practice. She recalled a flirtatious client who commented on her appearance and was curious about her social life, which Lucy appeared intimidated and bewildered by:

"God, you know, so I took it to my supervision and the supervisor saw it as 'negative behaviour' [and that I should] '...just ignore it'. So I ignored it, I ignored [and] it was getting worse and worse and in the end the client dropped out" (Lucy, L240-246).

Lucy appears to suggest that her supervisor's advice to ignore the client's flirtations, was counterproductive. Her apparent discomfort seems to reflect her inexperience and possible powerlessness, as a trainee, to challenge her supervisor's stance on her work. Lucy reflected, during her interview with me, that in hindsight, her non-engagement with the meaning of the *"sexual transference"* (Lucy, L246), is what caused the client's departure and that as a qualified practitioner she would now address this directly.

This subtheme reflected the varying ways in which participants, as trainee CoPs, struggled to cope with the erotic, sexual feelings that arose with clients and their various counselling psychology trainings did not seem to sufficiently support them in managing these experiences.

This was exemplified in Kate and Beth's recollections of training, which reflect most participants' reports of none to minimal training:

"In all honesty, I don't think my formal training had an awful lot to do with anything [laughing] in terms of sex, sexuality and gender stuff" (Kate, L70-71)

"I'm sure we had a couple of lectures. Honestly, I can't really remember very much about that. I'm sure we had one which was about pink therapy and working with LGBT clients." (Beth, L186-188).

However, these training experiences also suggest that good supervision is important, as there appeared to be a modelling effect, as Garrett (1998) proposes. This also raised the issue of how training organisations support the trainees in placement and monitor the quality of the supervisors in the placements their trainees attend.

To conclude, this master theme highlights how the combination of participants' liberating personal sexual experiences and/or discussions and the challenging discomfort they faced in therapeutic contexts, to address various sexual topics, triggered a deeper questioning and reflection of their earlier adolescent sexual attitudes (as illustrated in Master Theme 1). This allowed them to re-assess some of the differing ways sex and sexuality can be viewed, discussed and/or experienced. This corresponds with Simon and Gagnon's (2003) ideas relating to how participants' pre-existing personal sexual expectations interact and clash with clients' expectations of sexual conduct and highlights how both personal and professional understandings of sex and sexuality intertwine. This also supports Rønnestad & Skovholt's (2001) general, non-sexual specific finding that childhood and adolescent learning can affect professional therapeutic work in adulthood. However, this study, in contrast, specifically

highlights that the acquisition of adolescent sexual mis/information (or the lack thereof), impacts beyond adolescence and young adulthood and has influenced these participants as adults, both personally, in training and, as outlined in the next and final master theme, in their professional practice. This master theme also highlights some of the gaps participants felt they had in their training, as the following master theme will also expand on.

Master Theme 3

4.3 Varying degrees of confidence: Experiences as qualified practitioners

This final master theme illustrates participants' experience of varying degrees of confidence in talking about sexual issues with clients, as qualified counselling psychologists. Their confidence levels appeared to be affected by their overall journeys to understand sex and sexuality, from adolescence to adulthood and post-qualification. The subthemes identify four participants' lower levels of confidence and uncertainty in engaging in dialogue about clients' possible sexual issues. This is then contrasted by four other participants' greater confidence to break taboos and challenge clients' sexual ideas. The master theme ends with participants' more confident reflexive perspective that advocates that in order to work therapeutically with sex and sexuality, they need to be understood as mutable ideas with multiple meanings that necessitate continual revision.

4.3.1 The elephant in the room: To ask or not to ask

Four out of eight participants' implied an internal reticence to address the unspoken yet known, sexual *"elephant in the room"* (Fran, L193). These participants give the impression that sex was only discussed if their clients raised the issue first; or, when relationship issues provided an amenable context for sexual enquiry. Participants also seemed to have expectations as to whether sex may be relevant to particular client groups. Kate and Sophie said:

"I'm not sure I would ever bring it [sex] up with anybody spontaneously unless there was a very obvious kind of leading pathway to it" (Kate, L336-337).

"...[I am] quite happy to (...) get into it [sexual discussions] with a client if they kind of bring it and raise it and want to talk about it" (Sophie, L302-304).

Participants' uncertainty in creating appropriate contexts to enquire about sex, suggests their reluctance to be perceived, by clients, as asking about sex arbitrarily. This hesitance seemed to indicate the possible continuing influence of the social taboos highlighted in 4.1.1-4.1.3, as participants' seemed to rely on their clients to make sexual discussions more comfortable for them, as Hope acknowledges:

"It is quite a difficult subject for people to talk about. Maybe it's just my experience. Maybe it's me that was blocking that" (Hope, L390-391)**.**

Farnsworth and Callahan's (2013) notion of value conflicts, including unarticulated (unconscious) conflicts, appears to relate to Hope's suggestion that her own, perhaps unconscious discomfort, may have contributed to inhibiting clients from discussing sexual issues, when needed. Hope also seems to assume that sex would be a 'difficult subject' for her clients to talk about. It was almost as if participants were complicit in colluding and perpetuating the taboo that sex is unspeakable. However, it should be borne in mind that not all clients will have sexual issues (O'Donovan & Butler, 2010), albeit, it could be seen as important to clarify this with them. The hesitance to enquire directly about sex with specific client groups, was also illustrated by Sophie, in relation to single people:

"I don't know if I'd actually say it to someone who was single, didn't have a partner or wasn't kind of having sexual relationships of any kind. I don't know if I'd actually say (...) erm, yeah, do you masturbate and kind of that thing. (...) I don't think I'd do that. I don't think I ever have done that. Erm, I just, you know, for an individual who maybe doesn't have any kind of other relationships going on (...) If they're married or they've got a boyfriend or girlfriend or whatever, then I might actually ask, you know, how is your sex life and how do you find that, it is satisfying" (Sophie, L311-317).

Sophie seems to assume that sex (including masturbation), sexuality and relationships were possibly automatically irrelevant to the single individual. As only four out of the eight participants spoke of single people as sexual at all, this may indicate that participants could miss important information about single clients' experiences (or not) of sex, sexuality, relationships (and/or future relationships). In contrast, two participants' confidently countered these assumptions and appear to stress, similarly to Plummer (2003) that the intrapsychic and interpersonal experiences in the single individual 'are never entirely solitary' (Plummer, 2003, p. 13):

"...even if it's masturbation, (...) there's a fantasy other or a fantasy context and also we learn about what's acceptable and not acceptable, what's desirable, not desirable, I think, from the world around us" (Sarah, L259-262).

"...it is also a personal experience of... of your own sexuality that I guess doesn't necessarily involve other people, it's more how you present yourself and how you feel about yourself regardless of who you're attracted to" (Beth, L97-102).

Sarah and Beth's proposal that a person's relationship with and understanding of their self, as a sexual being (or not), is influenced by norms of acceptable sexual desire and is deemed just as important as how that person relates to their sexual partners and to their wider social world (Simon & Gagnon, 2003). However, single people were not the only focus of the relevance (or not) of sex and sexuality. Hope expressed surprise in her work with cancer patients:

"...[I thought] people will become much more concerned with some existential issues like much more higher level issues, not sexuality"; "But my experience at the moment is that actually

*people talk about it quite a lot"***;** as *"always the sexuality is a big part of that (...) it's a mixture around sex, intimacy, body image"* (Hope, L382-384; L392-393; L395-399).

Hope's experience seems to indicate that the profound impact of cancer (and cancer treatment) on the body, meant that she could no longer evade discussing sexual issues. It was almost as if the expectations of when sexual conversations were not permissible, created an impermeable, invisible barrier, until five of the participants felt they had to confront it. Sarah and Beth appear to actively challenge this barrier:

"You know, if you can talk to people about suicidal thoughts or toileting behaviours, why can't you talk to them about sex?" (Sarah, L123-125).

"I think, you know, eating disorders can be quite a specific (...) client group where I would say maybe most generic counsellors wouldn't really work specifically with eating disorders. But sexuality is kind of, you know, we're all sexual beings. We all bring sexuality with us wherever we go. So whatever the client is talking about he's still a sexual being. Someone with an eating disorder is still a sexual being. You know, someone who's whatever, they're still a sexual being" (Beth, L493-499).

Beth appears to assume the primacy of sexuality as an integral part of all individuals and implies that sex and sexuality are seemingly usurped in favour of issues that she argues are less commonly encountered. Both participants appear to hint at a sense of mystery, particular to sex, which rendered it unspeakable. This could perhaps be related to the power of the sexual taboo, referred to by Pope, Sonne & Greene (2006) to make sex seem off-limits. However, Sarah challenges this taboo, through her argument that that if other topics (taboo or otherwise), can be tackled, so can sex.

4.3.2 The diverse therapeutic contexts as sidelining and inhibiting sex talk

This subtheme focuses on how the diverse therapeutic contexts also appeared to impact on inhibiting participants from initiating conversations with their clients on sexual matters. This appeared to be both due to their expectations of whether or not sexual issues may arise in particular therapy contexts; and feeling that the context itself made the therapeutic space unsafe. Fran suggests that her work in an acute NHS psychiatric ward made it difficult to approach sexual issues:

"...with people with (...) more complex histories and problems (...) who are a little bit paranoid or scared, it's a bit more difficult" (Fran, L246-247) as she did not know: "...*how long these people will be around"* (Fran, L228-229) as *" trust is... is very important"* as it is one of the *"most intimate things you'll ever talk about"* (Fran, L249-250).

Fran suggests that 'intimate' sexual topics carried considerable emotional weight, particularly if *"sexual abuse"* (Fran, L241) was in the client's history. She indicates that asking about a client's sexual past could feel unsettling and unsafe, in the absence of a clearly established working alliance that could provide a safe, containing therapeutic frame (Luca, 2004; Sills, 1997). However, the threat to safety did not just apply to clients. Fran also said that, in relation to running group therapy:

"...sometimes I haven't felt safe, you know, exploring sexual issues in a group because I, you know, perhaps either I was the only woman or I just haven't felt comfortable in a group" (Fran, L323-325).

Fran suggests that the group's gender dynamics, felt uncomfortable and possibly, intimidating, particularly when she was the sole group facilitator. This implies that Fran may have felt under-supported or under-resourced in running these therapy groups and the safety of the therapeutic frame was then compromised.

The organisational pressure of short-term work with predetermined therapeutic goals, within the NHS, seemed to reflect three participants reporting minimal or non-existent sexual discussions with clients. Participants attribute this to the '*severe'* or '*complex'* mental health issues of NHS clients, such as 'psychosis' and 'bipolar disorder' (Kate, Sophie and Fran). Sophie reflects these participants' thoughts:

"...maybe the other problems sometimes overtake and you can get kind of caught up in, you know, erm, understanding those things and not necessarily, yeah, you kind of sideline some things" (Sophie, L290-292).

These participants indicate that sexual issues in these psychiatric contexts, were a lower priority than addressing clients' 'severe' symptoms. Sophie suggests that this could, in part, be due to time constraints; and the perceived therapeutic agenda to get clients *"in touch with reality"* (Kate, L294-295). This seems to tie in with the literature regarding the expectations, particularly in relation to depression (Hook & Andrews, 2005; Östman, 2008) and psychosis (D'ardenne & McCann, 1997; Marques et al, 2012), that sexual issues are not considered as possible contributors to a person's mental distress.

By contrast, Jen, appeared to recognise that sexual issues are present in the NHS, but it was her service's Improving Access to Psychological Therapies (IAPT) policy remit to focus solely on work

with clients that have depression and/or anxiety as their 'primary presenting factors', which made her struggle with feeling sexual issues were 'sidelined':

"So if somebody [a client] say, wanted to work with anger management or childhood sexual abuse, (...) the response is that we should be signposting to another service or, if it was bereavement, then it should be to Cruse (...) We're talking about cause and effect as if they're the same things. So, as I see it, anxiety and depression are just symptoms whereas if we're talking about a bereavement, that isn't a symptom. A bereavement is an event that's happened that may lead to depression or anxiety. And so to me it's complete insanity to say [laughing] we can't deal with bereavement but we can deal with depression because [exasperated sound]... (...) that's my internal struggle" (L360-372).

Jen suggests that her IAPT employer did not appear to fully understand that, instead of treating depression as a 'symptom', bereavement and/or child sexual abuse can be a cause or contributor to depression, rather than a separate issue that requires a referral. Jen's 'internal struggle' reflects her frustration to meet her clients' needs. She dealt with this by:

"Erm, so as best I can, erm, once the client is in the room, then I feel that my allegiance is to the client and not... not really to the economist who designed this system that is completely, to me, ridiculous." (Jen, L373-375)

Thus, Jen seems to rebel or resist the context of the organisational agenda within which therapy was offered, that conveyed sex as off-limits or taboo, to prioritise the client's needs. Three other participants did also acknowledge that sexual issues could be present within the NHS. Sophie appears to realise as she was being interviewed:

"...not to say that people don't have sexual problems, though, who... who've kind of come with that [the severe issues]" (Sophie, L272-273) and *"maybe it's [sex] not always viewed as important but actually it [sex] is part of someone's life..."* (Sophie, L290-293).

Sophie seems to identify that, in addition to organisational expectations, her own expectations regarding this client group, had initially downplayed the impact of sexual issues. Sophie's subsequent recognition that sex may be relevant to those with 'severe issues', appears to reflect a shift in her thinking, as later in our interview, she wondered whether she should ask her clients' about more directly about sex. Somewhat differently, Lucy saw sex and/or sexuality as very visible with her NHS clients:

"I think emotionally there still can be very severe issues. (...) sex and sexuality will still come up in the work. Erm, I think in a... in just a different way, I think. (...) I tend to see more personality disorders" (Lucy, L436-439).

These extracts highlight participants' differing experiences and expectations regarding whether or not talk about sexual issues will emerge in different therapeutic contexts. This became very apparent when participants compared their NHS work to their private practice. Three participants attribute the increased presentation of sexual topics in private practice to a combination of clients being seen as not: *"quite as complex"* and having more "time" for them (Sophie, L298-299). This gives the impression that private work was seen by participants as 'easier'. Beth, conversely, said that her private clients seemed *"embarrassed or awkward"* (Beth, L289) when sex was mentioned by her. She attributes this to their expectation that as they had come for general counselling, they did not expect sexual discussions to arise. This echoes three other participants' assumptions regarding the emergence of sexual issues in distinct therapeutic contexts, with Kate, Lucy and Hope saying:

"I think that most of the times when you're working in a kind of general practice thing I... I don't think that kind of stuff actually comes up very often. I suspect it's the kind of thing that most people get referred to a specialist for instead" (Kate, L100-103).

"I don't know whether it's because in the NHS they might be referred to a sort of sexual health department and see a psychologist there. That's what I'm assuming" (Lucy, 418-420).

"… [within GP settings, sex is a] much more hidden subject" (Hope, L323-324).

The above quotes imply an expectation that it is someone else's job to deal with sexual issues. However, Hope's use of 'hidden' appears to acknowledge that sex may be an issue in some contexts, but is, as Pope, Sonne & Greene (2006) argue, rendered taboo, by both the psychologist and the client. This finding also corresponds with Plummer's (2003) argument that it is not only social relationships, but legislative and institutional structures that can affect sexual meanings and when a sexual issue is deemed relevant. Participants' varying expectations and assumptions of different therapeutic contexts appeared to impact on whether or not they felt confident or not in considering and exploring sex and/or sexuality, within the context of their clients' presenting issues.

4.3.3 Breaking taboos

In contrast to the previous two subthemes, this subtheme identifies the greater confidence of four of eight participants, to broach sexual topics in the therapy room. Participants' apparent awareness that the sexual taboos they experienced while growing up, could affect their clients too, seemed to encourage them to actively strive to communicate to their clients that sex does not have to be taboo:

"... if we didn't ask about these things, it can give the message that we're not comfortable to talk about them" (Jen, L81-82).

"... it encourages an environment of... of taboo breaking and that anything goes and... (...) and being really curious about the person's whole experience of life, not just the polite bits or the... the acceptable bits" (Sarah, L217-219).

"... it's acknowledging how they feel, clearly, but not colluding with that as well. That you... you have to take a position of like you can do this here with me, (...) I can hear this if you like" (Lucy, 392-394)

These participants seemed to emphasise the value of giving clients permission to speak about sex, if they so wished. Equally, participants acknowledged the necessity of avoiding the recognised process of collusion (Lemma, 2003) with clients' possible discomfort/reluctance to talk, which could perpetuate sexual taboos. Participants' *"natural curiosity"* (Lucy, L407) to hear clients' 'whole experience' and accept 'not just the polite or acceptable bits' (Sarah), seems to indicate how these participants' appear to challenge and normalise their clients' perceived 'unacceptable' sexual lives, thus conveying their acceptance of their clients' experiences.

Three participants also stated that terminology was important in sexual discussions in order to overcome the taboo. Client uncertainty and lack of knowledge of sex and/or sexuality appeared to be demystified through participants' negotiation of a shared language that all parties in the therapy room would understand. Kate suggested that the social meaning of slang words for anatomy and different sexual activities: *"…change all the time and I think, to be honest, it's probably better if you just ask the person what they mean"* (Kate, L90-91). Kate seems to imply that by enquiring about clients' use of sexual words, she could quash any potential problematic

confusion or misunderstanding relating to rapidly changing meanings of colloquial/slang sexual terminology. Hope seemed to be in agreement with Kate, but nonetheless, appeared to value the input of training to have:

"...helpful words that... normalises talking about it [sex] and it kind of reduces the shame and anxiety talking about those issues" (Hope, L433-435).

In contrast to Kate, training appeared to give Hope the means to disarm her fears and feel more comfortable and confident in approaching her clients' sexual concerns. Furthermore, Sarah proposed that non-verbal means to *"negotiate words"* (Sarah, L276) for sexual anatomy, were useful when clients lacked "*words for their genitalia..."* (Sarah, L272-273). Her use of a *"puppet of a vulva"* (Sarah, L268) to help clients *"externalise"* (Sarah, L279) their feelings, she suggested, could foster a sense of:

"...play (...) and modelling an approach of curiosity, I think, to bodies and feelings (...). Respecting it without taking it too seriously" (Sarah, L288-290).

The use of a vulval puppet seemed to lessen client anxiety due to its apparent dual role, to educate clients about anatomy and lessen their discomfort; and normalise/empower their expression of feelings about their genitalia/bodies and the impact of this on sex. This is considered important by Bancroft (2009) and O'Donovan and Butler (2009), as client misunderstandings regarding what sex is, can create or perpetuate sexual problems. Whether verbal or non-verbal means were used by participants to make sexual discussion accessible, their strategies appeared to be generated from their increased confidence in knowing the effect of sexual taboos and developing the means to actively address misinformation.

4.3.4 Confidence to challenge clients' sexual ideas

This subtheme portrays how six out of eight participants' earlier journeys to reconcile their own adolescent understandings of sex (as reported in Master Theme 1), led to increasingly greater degrees of confidence in challenging their clients' sexual assumptions. Clients' understandings of sex were seen by participants as:

"...sex isn't always about intimacy" (Lucy, L149-150), or can be, with or without an *"emotional connection" (Beth, L64); "embarrassment" (Jen, Hope); "shame" (Lucy, Jen), "not feeling wanted" (Lucy, L203)* to *"malevolent and exploitative"; "abusive"; "repulsive and disgusting"* (Lucy, L163); and that clients are "*disturbed and distressed by their sex life"* (Sarah, L34).

These descriptors suggest that participants' perceptions of clients' understanding of sex, were not dissimilar to the ways in which participants understood sex in their adolescence (see 4.1.3). This could be understood to reflect participants' thoughts that beliefs absorbed, through their upbringing and sociocultural norms, about how sex *"should"* (Beth, L70) be. Sarah reflects on and challenges these assumptions:

"it's interesting (...) we're talking about it [sex] like it's a thing. But (...) when does it even count? Does it have to be penetration? (...) with a penis and a vagina? Does anal count? Does not having a penis count, using your fingers or a vibrator? (...) Do you have to have had an orgasm for sex? There's plenty of people that will have sexual activity that doesn't involve any genital rubbing or touching and it's just a kind of a mental state and (...) like dominant submission and play (...) It's definitely sexual what's happening but there isn't any kind of penetrative acts going on. (...) [there's] dirty phone calls (...) masturbation (...). We use (...) this word like it means (...) one thing and it means so many different things and it's so context dependent" (Sarah, L68-79).

Sarah's comments reflect all participants' recognition that the sexual norms, in both their past and present, was/is assumed to be the heteronormative (Weeks, 2010) "penetrative" (Lucy, L51), *"intercourse"* (Fran, L130). Five participants also questioned sex as not being a single *"thing"* (Sarah, L68), or *"penis and vagina sex"* (Kate, L41). These participants' also seem to recognise that differing values appear to be placed on various sexual activities and types of relationships. Sarah reflects this view:

"Erm, people can have really odd expectations about, you know, what an erect penis looks like or what a vagina should look like, or a vulva, or what erm... what an orgasm should feel like; erm, what sex should feel like, that, you know, what it should do to your relationship, what you're worth in terms of your sexual availability, how useful or important that makes you as a person. And it's really, really damaging..." (Sarah, L40-44).

"I think it's quite difficult to just define it [sex] (...) as one thing and (...) that is something that also causes a problem (...) in terms of what clients bring to therapy. That they might have an idea that sex should be like this, this is what I want to be doing but instead I'm doing this and I don't know how to get from here to where I want to be (...) but who told you that sex has to be like this, where did you get this idea and what is wrong with the sex you're having, why are you unhappy with that? I think, you know, a lot (...) does come from (...) our expectations of how much and when and with who and under which circumstances we should have sex and not meeting those expectations causes a lot of problems and issues" (Beth, L67-77).

These extracts clearly indicate these participants' awareness, as O'Donovan and Butler (2010) proposed, that sex and sexuality have multiple meanings that defy easy definition. These participants suggest that client sexual issues arise from the problematic, *"really really damaging"* (Sarah, L44-45) conflict between meeting the sexual norms expected from

partners/family/society and attempting to reconcile these expectations with their own sexual desires and expectations about sex, sexuality and their bodies, as exemplified by Simon & Gagnon (2003). It is therefore implied that participants' strategy for working with sexual issues was to encourage clients to question their own sexual assumptions, is broadly similar to how these participants' themselves had gone through their own journeys towards accepting their sexuality. However, their awareness of the need for this process did not always translate easily into the attempt to encourage clients' questioning of normative assumptions regarding sex, as illustrated in Hope's account:

" Erm, so... so it's quite sort of interesting also to hear that [there are alternatives to heterosexual vaginal intercourse] and, for example, to explore that there might be other ways of, erm, of, you know, being intimate with partners. Erm, yeah, that was quite simple to say that but it's not simple at all and it had... you kind of push this through all kinds of barriers with people" (Hope, L410-415).

Hope's halting dialogue seems to reflect her sense of having to, with difficulty, dismantle existing 'barriers', in both her and her clients' attempts to counter the dominant prevailing norms and feel comfortable around sex and sexuality. She also seemed aware of the effect that her struggle may have on her clients.

Seven participants' also appeared to challenge their clients' sexual assumptions with the use of psychological theory. By understanding and giving clients' an explanation for how their sexual issue emerged, the CoPs were able to disarm their client's anxiety about the issue:
"… I think also sometimes it's about not necessarily about sex as such but (...) how an individual can express their distress, emotional distress, or their distress in the relationship" (Lucy, L203-205).

"… say if you have a male client who's coming with erectile dysfunction, there may be a great deal of shame or embarrassment, erm, but actually if we shift to the symbolic meaning, it can alleviate some embarrassment". (...) You know, might it be that sometimes the body speaks and so if there is a feeling of... of disempowerment, erm, physically, is there anything in that relationship that... that perhaps feels emotionally disempowering" (Jen, L301-303)**.**

Lucy and Jen's examples illustrate how psychological explanations can mean sexual issues are a 'symbolic' and/or representative manifestation of issues in a person's relationship and/or life, which, when applied therapeutically, could 'alleviate' their client's suggested discomfort. However, participants varied as to which therapeutic approach they viewed as being useful for explaining and tackling clients' sexual 'distress':

"I suppose I probably draw mainly on my kind of CBT training and behavioural kind of stuff, erm, around sexual issues, definitely" (Sophie, L354-356).

"Theoretically, there's a place in the [psychodynamic] model where, I mean, and correct me if I'm wrong, that's my understanding, there isn't it in CBT" (Lucy, L536-538).

"I don't ever use CBT. Kind of keeping diaries, erm, challenging cognitions, that's not... I don't find it useful actually" (Sarah, L344-346).

The varying views of these qualified CoPs as to which therapeutic approach they found most useful, seemed to indicate that participants saw value in the approach that they preferred, to address clients' discomfort regarding their sexual issues and facilitate clients' critical reflections of their sexual assumptions. However, all participants identified that there was considerably

more to learn with regards to working with sex and sexuality and expressed openness to learning more, in order to assist their clients further.

4.3.5 Impact of the self in the therapeutic process: Confidence, openness and reflexivity

This subtheme illustrates all participants' recognition of the importance of and impact of self development in building their confidence to remain open to questioning sexual norms and examining their own sexual attitudes for themselves and in relation to working therapeutically with clients. Unlike accounts illustrated above (4.3.1-4.3.2) where participants had difficulty talking about sex with clients, here, Sarah and Jen referred to the confidence needed to risk sexual conversations:

"So, erm, I think it can feel dangerous though because there is a show and tell that goes on. When you start asking people about sex, your own values get exposed very quickly and difference then gets exposed" (Sarah, L221-223).

"Erm, how comfortable might they [clients] feel about disclosing something very personal. Erm, you know, often if we want to be seen as attractive by the other person, erm, does that mean we're not so comfortable to disclose something that we feel might... might be an unattractive thing" (Jen, L242-245).

Sarah gives the impression that she felt confident to take the '*dangerous'* and *"frightening"* (Sarah, L238) risk of revealing her own sexual values through her conversations with clients. The intersubjective effect of client and therapist on each other (Lyons-Ruth, 1999; Stolorow and Atwood, 1997; Orbach, 2007) is highlighted by the exposing *'show and tell'*, which leaves each party open to the judgment of the other. Jen also appears to highlight what she saw as the client risk of discomfort at being perceived as 'unattractive' (by the practitioner), in revealing

‘personal’ sexual disclosures. These experiences appear to refer to participants’ awareness that confronting their own sexual attitudes was necessary to develop their professional skills in facilitating sexual discussions. Furthermore, participants’ indicated the need for openness to differences in their clients:

“...pretending that my way of having sex is the same as someone else’s again isn’t helpful but you need to be curious about the difference” (Sarah, L596-597). This curiosity and confidence to notice the ‘difference’ was reflected in seven participants’ accounts and is illustrated through Hope and Sophie’s extracts:

“I have come a long way, I think, within myself. ‘Cause I think, erm, for myself I’ve got quite a lot of openness to difference and... (...) and different expressions (...) and different ways of, you know, being sexual. I think that I... It’s quite fun, in a way, and I’ve got that internal thing that is not scared or it’s, erm, it’s open and, erm, welcoming. You know, looking for difference and enjoying the difference” (Hope, L561-566).

“I guess I was making assumptions in my head and thinking okay, I think this person may be... might be bisexual but actually wanting to hear from her how she perceived her sexuality (...) ‘Cause I think it’s quite easy to be kind of caught up in all the boxes and different things when actually... and that probably causes problem... more problems for people than, erm, yeah, allowing them to kind of explore and understand without the boxes, if that makes sense?” (Sophie, L438-445)

Hope’s extract highlights participants’ journeys from seeing sex from within the frame of the *“restrictive”* (Hope, L560) sexual norms of their adolescence, to their present more open attitudes. This seems to reflect a process that Hope describes as the journey to feeling

comfortable with *"owning sexuality"* (Hope, L429). This shift in their power to critically evaluate, for themselves, their own assumptions, prejudices and expectations, appeared to allow them to go beyond problematic 'boxes' and explore a greater diversity of meanings of sex and/or sexuality, both personally and within the professional therapeutic context.

In common with Ford and Hendrick (2003) and Riessing and Di Giulio's (2010) findings, participants' growing sense of confidence in discussing sexual issues, despite the fact that none of them had any formal psychosexual therapy qualification (though some had done some short courses), was linked to the range of sexual issues they encountered in practice. These sexual topics included (amongst others): Sex within the context of relationship issues; when to have sex (Kate); negotiating sex and the body (cancer/HIV/body image; Hope, Beth, Sarah); specific 'sexual problems' such as '*erectile dysfunction'* (Kate, Sophie) *'premature ejaculation'*, *'performance anxiety'* and *'vaginismus'* (Lucy and Sophie); *'sexual abuse'* (Fran, Jen, Lucy, Sarah); *'rape'* (Beth, Sarah); *'sexual identity'* (Fran); *'transgender'* issues (Jen and Sarah); and 'non-problematic' sex that was mentioned in passing and not focused on. These varied sexual issues were particularly significant as all participants reported minimal to no training in discussing sex on their counselling psychology courses (see 4.2.3). It seemed that participants were expected to do their "*own research"* (Sophie, L127) or educate themselves via other courses, in order to build confidence in their sexual knowledge in relation to therapeutic practice. The practitioners that were more confident seemed very willing to recognise that there were *"...gaps in (...) [sexual] knowledge"* (Sophie, L458) and identify their training needs:

"I've never felt like I was trained enough to (...) see sexual problems as a goal for therapy. So, erm, I don't think, erm, I will know enough. Or I don't feel like I know enough to... to be able to work on those issues with clients yet" (Fran, L283-286).

Sophie and Fran's comments appear to reflect the varying degrees to which these qualified participants' increasingly felt comfortable to acknowledge feeling deskilled in particular aspects of working with sexual issues. Fran seemed to work confidently with sexual identity and in her work with clients with possible sexual abuse histories, in her 6 years of post-qualification experience . Yet, she expressed a wish to learn more, particularly regarding *"sexual dysfunctions"* (Fran, L292), such as *"premature ejaculation"* (Fran, L340). This highlights that within the range of sexual topics that CoPs faced, that, although confident, there was variation in which aspects of sexual understanding these CoPs felt they could work with competently.

All participants, in interviews with me, expressed a wish to lessen the gaps in their theoretical and practical therapeutic knowledge relating to working with sexual issues. In particular, the participants who appeared more comfortable acknowledging their *"not knowing"* (Sarah, L173), seemed happy to proactively seek further information regarding unfamiliar sexual topics:

"...just asking people's advice on things about can they recommend films or books and... and being quite transparent about my not knowing of their experience" (Sarah, L171-173).

"...through my (...) experience with clients and talking to them (...), that would lead to one thing and then I'd maybe go away and kind of, you know, talk about it in supervision or do my own reading and research on something" (Sophie, L137-141).

Sarah's direct acknowledgement, to clients, of the shortfall in her knowledge, implied that she tried to communicate that she did not have more expertise than her clients. Her open curiosity to learn about her clients' issues, gives the impression that rather than appearing clueless, she was willing to share her clients' journeys. This absence of fear of the lack of knowledge was also indicated in Sophie's account. While Sophie might not directly ask her clients for information,

she indicated her active search for information from other sources. All participants cited seeking information outside client work or CoP training, albeit, Sarah argued that in order to work with sexual issues, only a minimal amount of knowledge was needed regarding the biological sexual mechanisms such as:

"...body parts and a bit of physiology, erm, which is a steep learning curve but, to be honest, you can probably nail it in a few days [by reading books]. The rest of the knowledge is about (...) how to think. (...) It's about letting go of certainty of anything, I believe" (Sarah, L571-572)

"... You know, [there's] an idea that you have to somehow be a sexual expert to talk about sex and you don't. It's got... You just have to be nosey about yourself actually, I think" (Sarah, L659-661).

Sarah's bold statements suggest that questioning and challenging of one's own views and feelings about sex is, to an extent, more important than practical biological knowledge, which bears out Noland's (2009) finding. The 'letting go of certainty' of 'assumptions', Sarah implied, can go a long way to feeling comfortable with discussing sexual issues, before the practitioner needs specialist knowledge. To this end, these participants' acknowledged that their process of becoming more comfortable discussing sex, necessitated continuing education and self-reflexivity:

"I think as commissioners we do have a responsibility there to think about these [sexual] things. So I think if you're not aware of it, you know, you just don't know what you're blocking unintentionally, you know, if you haven't thought through these things" (Lucy, L489-492).

"I think always remembering that we don't know everything and we're not necessarily always right and no matter how long we've been doing something, and maybe <u>*especially*</u> *if we're doing something a long time, that it's important to, you know, be questioned and to (...) hear different perspectives and different viewpoints and, erm, you know, to listen to people of all ages and all... all stages of their careers"* (Jen, L387-392).

Jen and Lucy appear to highlight the importance of counselling psychologists' implied ethical and *"professional responsibility"* (Lucy, L506), (BPS, 2005; 2009; Bond, 2009) to examine and explore their own feelings and experiences in relation to sex, sexuality and the therapeutic process. This would ensure that participants' do not suppress/repress or 'block unintentionally', feelings, attitudes and behaviour that could detrimentally affect their clients' articulation of sexual issues. The participants' journeys from adolescence to qualified counselling psychologists appear to illustrate their understanding of the non-static, diverse meanings of sex.

These participants' reported that their sexual attitudes shifted over time and they acknowledged that their attitudes would, most likely, continue to change. All participants recognised the need to remain open-minded and continually re-evaluate their sexual ideas throughout their careers. Jen, in particular, with over 10 years post-qualification experience, implied that one must be careful to guard against complacency, 'especially' over a 'long time', in considering the effect of how participants' understanding of and approach to working with sex and sexuality in the therapeutic context, impacts on clients.

These results, overall, highlight how participants negotiated the multiple influences of sexual norms, throughout their lives, relating to sex and sexuality. Participants' journeys towards more complex and empowered sexual understandings were not straightforward. The negotiation of fear and uncertainty due to the legacy of restrictive and taboo sexual norms in adolescence was

challenged in adulthood through personal sexual experiences and discussions. The taboo legacy and varying contemporary work contexts also appeared to contribute to participants' varying degrees of struggle in addressing sexual topics, during training and as qualified counselling psychologists. However, participants' openness to new ways of thinking about sex and sexuality allowed them to question their sexual assumptions, both personally and professionally. This allowed them to continually reassess the complex changing ways in which sex and sexuality can be considered and thus adopt a more reflexive and empowering approach to working with clients presenting with sexual issues.

CHAPTER 5 DISCUSSION

5.1 Introduction

This chapter will discuss the findings of this research in answering the research question: *"How do counselling psychologists understand and experience working therapeutically with sex and sexuality"*? Three main findings were identified from eight CoP participants' accounts. Firstly, the taboo culture experienced by participants in their adolescence left a legacy that appeared to carry over, to some extent, into their training and professional work. Secondly, participants' transitional journeys to work with sexual issues seemed to be influenced by a combination of their personal sexual experiences as young adults and their encounters with sexual issues as trainees, in the therapy room. These experiences led to unexpected feelings and thoughts about sex and sexuality with which they had to find ways to work. Thirdly, as qualified CoPs, these participants appeared to demonstrate their growing (albeit varying) confidence as a result of flexibly reflecting on their own personal attitudes and their professional work. From these three findings, the overall conclusion of this study identifies that participants' ability to question their own and their clients' sexual understandings, emerged from the recognition that meanings of sex and sexuality constantly change and therefore require an ongoing self-reflexivity. This self-reflexivity allowed participants' to refine understandings and enhance their continuing professional development.

5.2 Contributions of this study in relation to the existing literature

This qualitative research has offered a richer depth of perspective from participants' lived experience which highlights the mutability of sex and sexuality, in contrast to the top down findings of quantitative research that provide more essentialist claims on the nature of sex and sexuality. Considering the three main findings noted above in more detail, there are a number of possible contributions to the psychological and therapeutic literatures that are noteworthy.

Firstly, there was a sense, from these participants' accounts, that their power over their own sexuality shifted (to varying degrees), in response to how circulating sexual norms changed, from the taboo culture of their adolescence (see Master Theme 1) to the sociocultural contexts they inhabited in adulthood. For example, the religious background of 5 out of 8 participants, which seemed to be a significant contributor to the aforementioned taboo culture, was particular to this group of participants and may not be generalisable to the experience of all CoPs.

However, it is important to acknowledge that the literature also indicates that irrespective of religious background, a general reluctance has been found in parental and school contexts, to provide reliable and effective information on sex (Guasp, 2012; Kim, 2011; Mac an Ghaill, 1994; Measor, 1996; Measor, 2004; Mercer et al, 2013; Ringrose et al, 2012; Shakespeare et al, 1996; Wellings et al, 1994). A similar trend is evident in Lee's (2003) findings that refer to the ambivalence of participants' mothers' attitudes towards the body, menstruation, sex and sexual expression. Participants' fathers' also expressed sexist attitudes to their daughters' bodies and sexuality, which was attributed to the 'male gaze' (Mulvey, 1975). Thus, such sexual 'double standards' (Crawford and Popp, 2003; Holland et al, 2004; Lyons et al, 2011) cannot be exclusively attributed to the influence of religious beliefs. This finding highlights that the potential for a taboo culture is still evident, regardless of whether or not religion is a contributory factor. This does not detract, however, from the importance that these particular participants' gave to the influence of religious attitudes and values on their initial understanding of sex and sexuality as being taboo.

The second key finding of this research identified that the consequence of a taboo culture and/or participants' pre-existing personal sexual understandings were at times challenged by their personal experiences and when their sexual understandings conflicted with those of their clients (see Master Theme 2). As trainees, these CoP participants had to find ways of managing

these conflicts. Relating this finding to the extant literature, two theories offered useful explanations for how CoPs' were able to renegotiate and reconfigure their personal sexual ideas which then impacted on their practice. Simon and Gagnon's (2003) sexual script theory identified how participants' re-evaluated their own personal sexual ideas in relation to the social context and sexual norms of both society and clients. This was illustrated through the reported impact of participants' use of personal therapy to enhance (productively) their personal and professional development, a finding that has been confirmed in numerous studies (Grimmer & Tribe, 2001; Macran et al, 1999; Rizq & Target, 2008a; 2008b). Farnsworth and Callahan's (2013) client-clinician value conflict theory, in contrast, gave a therapy specific explanation for handling conflicts that arise in therapy. Participants in this research appeared to utilise the strategies offered by Farnsworth and Callahan (2013) for tackling these conflicts, such as Beth (see 4.2.2) in finding out more about her clients' sexual worlds, or participants' general use of supervision when dealing with erotic feelings in the therapy room.

Participants' apparent lack of training in dealing with the process of erotic transference and countertransference (Celenza, 2010a; 2010b; Jorstad, 2002; Lemma, 2003; Marshall, 2010; Mann, 1999; Rouhalamin, 2007; Sherman, 2002) was also borne out by the literature (Ladany et al, 1997; Ladany et al, 2005; Riessing & Di Giulio, 2010), although Ladany et al's (1997; 2005) finding that trainee therapists are less likely to disclose the emergence of sexual feelings in client or practitioner, to their supervisors, contrasts with the results of this study. This may reflect a particular emphasis in these particular participants' and/or their training placements or, within CoP courses themselves, on the importance of supervision. Furthermore, this study's finding that supervisors play a role in modelling to therapists, how to conduct therapy, corresponds with Garrett's (1998) identification that good supervision is crucial, because if the supervisor's modelling effect is poor, it can be detrimental to the client-therapist therapeutic relationship, as

borne out by Lucy's example of her client dropping out (see 4.2.3) when she did not engage with what is recognised as sexual transference.

The interaction between personal sexual understandings and professional work was highlighted across all master themes and corresponds with Rønnestad & Skovholt's (2001) contribution of the relationship between early and adult life experience and the input of professional experience, in the professional development of therapists. Although Rønnestad & Skovholt's (2001) research was more generic and not specific to sexual understanding in relation to professional work, this present study offers some insight into this. Participants' confidence in working with sexual issues (Master Theme 3) seemed to relate to their move from their earlier normative sexual understandings to be able to, in contrast to their adolescence, as adults, feel comfortable with 'owning' their sexuality (Hope, see 4.3.5). This seemed to occur when participants' were in new contexts (both personal and training/professional) that challenged their pre-existing assumptions and gave them alternative ways to consider meanings of sex and sexuality (see Master Theme 2). These CoPs' experiences of the above, gave them the confidence and means to draw on their therapeutic self-reflexive skills (Bager-Charleson, 2010; Hedges, 2010) to critically re-evaluate their understandings of sex and sexuality, which developed more complexity as they progressed from adolescence to qualified status.

However, it is acknowledged that not all these qualified participants were equally confident to address sexual issues. Expectations regarding when sex and/or sexuality might be an issue, seemed to vary depending on the therapeutic agenda of the organisational setting within which participants' worked. This was despite evidence that suggests sexual issues are relevant in varying psychological and psychiatric contexts (D'ardenne & McCann, 1997; Fergusson et al, 2008; Hook & Andrews, 2005; Marques et al, 2012; Östman, 2008; Spataro, 2004). The difficulties highlighted here, may have been related to what Stephenson (2010) described as the

power dynamic between client and therapist, particularly in relation to demographic factors such as gender, age, ethnicity and sexual orientation. For example, Kate's ease (see 4.2.2), as a trainee, at addressing age or gender rather than sex, also highlights this complex interplay that Riggs and das Nair (2012) describe as the intersection of different cultural identities and how they are understood. These expectations can also be explained in terms of Plummer's (2003) reference to legislative and institutional structures that impact on expectations as to when and how sexuality can be discussed.

By contrast, the participants that did feel confident to address sexual issues, reported that sex was typically and heteronormatively assumed to be PVI, a finding that is consistent with the literature (Kinsey et al, 1948; 1953; Masters and Johnson, 1966, 1970, 1979; Masters et al, 1982; Mercer et al, 2013; Sanders & Reinisch, 1999; Pitts & Rahman, 2001; Randall & Byers, 2003; Weeks, 2010). However, the processes of negotiating rules of sexual conduct (Simon and Gagnon, 2003) and/or managing therapeutic conflicts (Farnsworth and Callahan, 2013), alongside these CoPs' self-reflexivity, facilitated most of these participants to be open to recognising the possibilities of a greater diversity of what can be considered 'sex' and/or 'sexuality' (see 4.3.4). Five participants had touched on some of this diversity (see 1.2 and 2.5.1) referred to in the literature by Barker, Bowes-Catton & Iantaffi et al, 2008; Barker & Langdridge, 2008; Berry & Barker, 2014; Barker, Iantaffi & Gupta, (2008); Bogaert, 2004; British Psychological Society, 2012;Davies, 1996; Denman, 2004; Przbylo, 2011. This suggests that self-reflexive CoPs are able to adopt an openness and flexibility to new sexual ideas.

Participants' were also able to recognise how their own sexual values and biases may be different from those of their clients and to acknowledge how the differences may intersubjectively impact on each other. Consequently, the intersubjective and relational therapeutic processes (Kahn, 1997; Lyons-Ruth, 1999; Stolorow & Atwood, 1997; Orbach, 2007;

Rogers, 1957; Woolfe et al, 2010) appear to support a self-reflexive way of approaching work with clients' sexual material. Participants' confidence in their reflexivity allowed them to counter sexual taboos and give clients' permission to discuss their sexual concerns. Alongside this they reported a willingness to challenge their clients' own sexual understandings by exploring how their sexual meanings emerged and how these meanings contributed to their present sexual issues. These participants thus acknowledged the impact of both personal and social meanings on clients' sexual understandings, as well as on how these clients' journeys seemed to be a reflection of their own, which appeared to highlight how these CoPs' own personal experiences influenced how they approached working with client sexual topics.

5.3 Possible contributions to counselling psychology

This section examines the implications of this research for the training and practice of counselling psychology. It has highlighted that the wide range of client sexual topics presented to CoPs, make sex and sexuality very relevant to the practice of counselling psychology. It has also illuminated how social norms impacted on personal sexual understandings and demonstrated how working with sex and sexuality may be negotiated, both personally and in relation to client work in CoP practice. It is acknowledged that CoPs' formative years are likely to affect their sexual understandings, although, regardless of their backgrounds, they will carry varying attitudes to sex and sexuality, which may present challenges. This study suggests that these challenges can be met through participants' developing confidence, as practitioners, to adopt a self-reflexive approach to this domain of client work. A key issue seemed to relate to how CoPs reach the point of being self-reflexive, especially when evidence suggests that even amongst sex and/or sexuality specific training, not enough time is given to evaluating sexual attitudes and their potential destructive impact for client work (Ridley, 2006). To this end, the need for good quality supervision was also highlighted, especially for trainees (such as Lucy

demonstrated in 4.2.3, when her client left) who may not be sure whether or not a supervisor's advice is appropriate.

Some of the gaps in training counselling psychologists are also highlighted, particularly as participants' reported minimal training in sex and/or sexuality. Counselling psychology's capacity to draw on multiple strands of knowledge and resources appears to be particularly well placed for working with sexual topics. Training possibilities include having opportunities to work with a broad range of sexual issues; having a working knowledge of sexual functioning, including anatomy and physiology; learning how to manage erotic transference and countertransference; having a working understanding of the diverse sexual identities and practices that CoPs may come across and how these identities may intersect with other identities (Riggs and das Nair, 2012); for which, the British Psychological Society's (2012) guide to working with sexual and gender minority clients, is a useful starting point. Working with sex and sexuality has often been seen as the preserve of specialist psychosexual therapists, however, overall, what emerges as important, through this research, is the need for CoPs to be curious about and question their own understandings of sex and sexuality. This emphasises that there is a wide scope of professional capability before a CoP may need to refer to a specialist.

Further considerations for CoP, relate to the expectations that CoPs may have regarding when a sexual issue is therapeutically relevant and when it is 'appropriate' to ask about sex. There is a possible risk of consciously or unconsciously 'colluding' (Lemma, 2003) in clients' reluctance to discuss a sexual topic that may be important to them. However, as with any particular therapeutic issue, the way sexual issues are conceptualised and worked with, as found in this research, may also depend on the therapeutic approach used (Woolfe et al, 2010). At a social and organisational level, an examination of why sex and sexuality are lower down the 'issue' hierarchy, in relation to both training and addressing sexual issues in therapy, could be

considered. Finally, these research findings and the extant literature (Simon and Gagnon, 2003; Plummer, 2003) suggest that the social context cannot be separated from individuals' understandings of sex and sexuality. It is therefore important to consider how the social context affects clients' experiences and understandings of their sexual lives. Furthermore, as CoPs are not outside of this social context (Hodges, 2010), a recommendation is proposed that CoPs need continual self-reflexivity and professional development training, so as to keep themselves and their clients' therapeutically engaged and ethically safe from harm.

5.4 Evaluation of this research

An IPA methodology was chosen for this study as it was considered the most suitable to meet the research aims. Its ability to provide a detailed exploration of CoPs' subjective understandings and experiences of working with sex and sexuality, therapeutically, meant the participants' experiences would provide rich data from which to draw conclusions. As IPA focuses on idiographic (Eatough and Smith, 2008) or particular groups of people, in a particular time and place, this study of 8 counselling psychologists may seem limited, in that it has presented specifically female CoPs' views of sex and sexuality which may well be different from other potential CoP perspectives .This research may not, therefore, be generalisable to the whole of counselling psychology. Nonetheless, it is hoped that these findings will still contribute to enhancing the awareness of some of the processes that seem to affect CoPs' understandings of sex and sexuality; and how these understandings affect whether or not such issues are addressed in their client work. These findings may also apply more generally to those in other therapeutic disciplines.

In recognition of the hermeneutic process (Eatough and Smith, 2008) involved in analysing the data, this highlights the inevitably subjective nature of IPA research (Willig, 2008) and the results presented here, are just one of many possible interpretations. However, the homogeneity of the

participants, who were all female, white, heterosexual and either from England/Europe, suggests that a rather narrow view of sex and sexuality may have been presented. This is particularly the case as 5 out of the 8 participants did have strict religious backgrounds which they seemed to attribute to their early understandings of their sexuality and what they thought sex is.

The significant number of Catholic or formerly Catholic participants also raises questions as to who might be drawn to participate in this kind of research. Timmerman (2001) and Sheldon (2006) echo the participants' suggestion that Catholic religious doctrine can cause a lot of guilt and/or shame in many areas, including sexuality. It could be inferred that the research interview offered participants the opportunity to reassess and share past and current meanings of sex and sexuality and perhaps, retaliate against their previous restrictive sexual contexts in ways that empowered them, both personally and professionally. This also has implications for future research (see 5.5). The participants' experiences do nonetheless have value as they did vary in how they understood sex and sexuality; and the research method did offer a means to understand the process of these CoPs developing confidence in working with sexual issues, by the means of self-reflexivity.

In relation to my own reflexivity as the researcher (introduced in Chapter Three, 3.6), it is inevitable that my own subjectivity will have drawn me to particular aspects of the data more than others which will have influenced the findings and contribution of this research (Brocki & Wearden, 2004; Finlay and Gough, 2003; Smith et al, 2009; Willig, 2008). My non-heteronormative perspective may well have contributed to how this research was interpreted, despite the attempts I made to 'bracket off' (Smith et al, 2009) my own biases and stay as close to participants accounts as possible. As explored in Chapter Three (section 3.6), my own experiences of working with sexual issues, as a trainee CoP, was a 'double edged sword'. In some

ways, it was harder to separate my own views from my participants, yet, at the same time, with the use of research supervision and familiarity with relevant literatures, it allowed me to connect with and understand further, what my participants might mean or be communicating that would be of relevance to counselling psychologists as the main target audience.

I also learned from my participants that although sexual knowledge is important, being comfortable with discussing and critically reflecting on sex and sexuality, alongside being receptive to learning new information is perhaps, more important for being able to work with clients' sexual issues. This information then had to be put to one side to be able to complete my analyses before then being reconsidered. This complex interplay of this 'quadruple' hermeneutic (see 3.6) is therefore significant. Furthermore, in keeping with the critical realist stance of this research, I was also mindful of the fact that the more visible differences between me and my participants, such as my being a British Asian deaf woman might have affected what these participants' chose to share with me, during the interview process. In relation to being deaf, my communication needs were explained prior to interviews and participants were invited to ask any questions beforehand and this did not seem to cause any problems. Thus, although no obvious issues emerged, it was something I was alert to and ready to address if needed.

5.5 Suggestions for further research

There are many fruitful possibilities for how research relating to sex and sexuality in counselling psychology could be developed. Firstly, a quantitative survey, similar to Shaw et al's (2007) survey of clinical psychology teaching programmes, as to what is taught, regarding sex and sexuality, would be useful. A quantitative survey would have a larger reach than qualitative research and could be distributed to all CoP course programmers and/or CoP students. The outcome of this survey would complement any subsequent qualitative research conducted. Secondly, exploring the clients' perspectives by means of a qualitative study, would enable an

understanding of what contributes to the client feeling able to raise sexual issues in therapy. Thirdly, comparative IPA analyses could be conducted, for example, with non-heterosexual CoPs, younger CoPs, non-religious CoPs or non-White CoPs, to provide differing cultural perspectives on possible understandings of sex and sexuality. Fourthly, another possibility would be to use grounded theory (Glaser and Strauss 1967; Strauss & Corbin, 1990; Charmaz 2005) which would allow for more diverse samples to triangulate and consider more varied social elements that could impact on sexual discussions. Alternatively a Foucauldian discourse analysis could identify in more detail, the discourses produced by power structures that influence talk about sex (Foucault, 1981; 1986; 1988). Finally, this research has identified the significance of the processes of change, confidence and self-reflexivity in relation to sexual understandings, with different theories attempting to explain this process (Simon and Gagnon, 2003; Farnsworth and Callahan, 2013; Rønnestad & Skovholt, 2001). Exploring further, how this process of self-reflexivity occurs and how it could be facilitated in training, could be fruitful.

5.6 Overall conclusion

This qualitative research has analysed the accounts of eight qualified CoPs. The Interpretative Phenomenological Analysis derived master themes illustrated how these participants negotiated multiple influences from their adolescent, adult, training and professional lives to recalibrate their understandings of sex and sexuality in order to work with clients' sexual issues. This study has also highlighted that although the taboo culture seemed to shape participants' earlier understandings of sex, it was possible for them, to a greater or lesser extents, (albeit, for some, with great difficulty), to move on from their pre-existing sexual norms and assumptions. Some participants' willingness to be challenged and practice self-reflexivity, illustrated their awareness of the relationship between personal sexual meanings and the impact of these meanings in therapeutic work. In particular, participants' increasing confidence to work with sexual issues,

also allowed them to challenge their clients' own sexual assumptions, especially in relation to heteronormativity, in order to give clients a greater sense of sexual freedom.

This qualitative research has presented an alternative view to the existing quantitative research on sex and sexuality, by providing a deeper insight into what influences understandings of sex and sexuality and how these understandings impact on therapeutic work. It is also one of the few to focus specifically on CoPs' experiences in this domain of therapeutic work. This study has highlighted how the sociocultural environment can significantly impact on sexual meanings and understandings; and has identified that the organisational context can also contribute to how sex is addressed or not, within the therapy room. It has also acknowledged these CoPs' openness to critical self-reflexivity in identifying their continuing professional development needs, particularly in view of the limited training reported on their CoP courses. This research also indicated where further research and practice knowledge can contribute to counselling psychologists' work in the sexual field, as well as enabling them to reflexively recognise where the limits of their knowledge lie.

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8 APPENDICES

8.1 UNIVERSITY OF ROEHAMPTON ETHICAL APPROVAL CONFIRMATION.

Ethics Application Ref: PSYC 11/ 030
Jan Harrison
Mon 09/01/2012 13:11
To: Anupum Kumar <kumara@roehampton.ac.uk>;
Cc: Lance Slade <L.Slade@roehampton.ac.uk>; Diane Bray <D.Bray@roehampton.ac.uk>; Lyndsey Moon <Lyndsey.Moon@roehampton.ac.uk>;

Dear Anu,

Ethics Application

Applicant:	**Anupum Kumar**
Title:	**Research title: Sex talk in therapy: Psychological therapists' understanding of sex and sexuality in the therapeutic context.**
Reference:	**PSYC 11/ 030**
Department:	**Psychology**

Many thanks for your response and the amended documents. I am pleased to confirm that all conditions for approval of this project have now been met. We do not require anything further in relation to this application.

Please advise us if there are any changes to the research during the life of the project. Minor changes can be advised using the Minor Amendments Form on the Ethics Website, but substantial changes may require a new application to be submitted.

Many thanks,

Jan

Jan Harrison
Ethics Administrator - Research & Business Development Office
University of Roehampton | Froebel College | Roehampton Lane | London | SW15 5PJ

8.2 RECRUITMENT POSTER

Talking about sexual issues with clients

Would you be interested in talking about your experiences of talking to clients about sexual issues?

Are you:

- A qualified counselling psychologist with experience of working either directly or indirectly with client sexual issues?
- You may or may not have had formal training in working with sexual issues.

For further information please email Anu Kumar:
kumara@roehampton.ac.uk

This research is part of my doctorate in counselling psychology at Roehampton University and has ethical approval.

My supervisor is Dr Lyndsey Moon,
Roehampton University, Whitelands College, Holybourne Ave,
London, SW15 4JD.
Tel: 020 8392 5773

8.3 RECRUITMENT EMAIL

Talking about sexual issues with clients.

I am doing research as part of my counselling psychology doctorate into psychological therapists' experiences of talking to clients about sexual issues. This will entail one to one interviews lasting approximately 60-90 minutes.

I am looking for qualified counselling psychologists with experience of working either directly or indirectly with client sexual issues, and with or without formal training in working with sexual issues.

If you would be interested in talking about your experiences or would like to find out more, please contact: kumara@roehampton.ac.uk

If you are outside of London and want to be interviewed, please contact me to find out if we can arrange something.

All information received is confidential and any material used in the research write up will be anonymised.

This research has received ethical approval from Roehampton University and is supervised by: Dr Lyndsey Moon and Dr Jean O'Callaghan, Roehampton University, Whitelands College, Holybourne Ave, London, SW15 4JD. Tel: 020 8392 5773.

8.4 INFORMATION FOR PARTICIPANTS AND CONSENT FORM

ETHICS COMMITTEE

PARTICIPANT CONSENT FORM

Title of Research Project: "How do counselling psychologists understand and experience working therapeutically with sex and sexuality?"

Brief Description of Research Project:

Limited research has been done on the how therapists feel about working with clients who bring sex and sexuality issues. As a trainee counselling psychologist and as a researcher, I am interested in how you feel your knowledge, experience and training does or does not help you in your understanding of sex and how you work with clients with sex and sexuality issues. This research is a chance to explore your experience of this and your input is greatly appreciated.

All interviews will be recorded and transcribed; any personal or identifying details will be removed or altered to protect your identity. Transcripts may be used in my report (though I will endeavour to primarily use aggregate data) and in any publications arising from it and recordings may be heard by my supervisor or those examining my report.

Anything said throughout the course of participation will be treated confidentially. However, if any information disclosed suggests harm might be caused to the participant or to others, I may need to take appropriate action (in accordance with the ethical guidelines of the British Psychological Society).

A full debrief will be provided at the end of the interview.
The interview will last up to 90 minutes.

Investigator Contact Details:

Anupum Kumar
Department of Psychology
Roehampton University
Whitelands College
Holybourne Avenue
SW15 4JD
kumara@roehampton.ac.uk

Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw at any point. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings.

Name ………………………………….

Signature ………………………………

Date ……………………………………

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However, if you would like to contact an independent party please contact the Head of Department (or if the researcher is a student you can also contact the Director of Studies).

Director of Studies Contact Details:
Lyndsey Moon
Roehampton University
Whitelands College
Holybourne Avenue
SW15 4JD
lyndsey.moon@roehampton.ac.uk
020 8392 5773

Head of Department Contact Details:
Diane Bray
Roehampton University
Whitelands College
Holybourne Avenue
SW15 4JD
d.bray@roehampton.ac.uk
020 8392 3627

8.5 PARTICIPANT DEMOGRAPHICS FORM

Background information

I am gathering this information so that I have some idea of what makes up the group of people that I speak to. You can answer as many or as few of these questions as you feel comfortable with. This information is not used to identify you in any way and will not be kept with your contact details.

1. How old are you?

2. How would you describe your gender?

3. How would you describe your sexual orientation?

4. What would you consider your cultural/racial/ethnicity to be?

5. What religion are you, if any?

6. What was your previous occupation, before becoming a psychologist/therapist, if any?

7. Could you tell me what training in therapy you have done and/or are doing, and the dates?

8. What therapeutic approaches have you learned and how would you describe your current therapeutic theoretical orientation?

9. During the course of your therapy training, have you completed (please tick for sex, gender, sexuality):

   - A lecture on sex
gender
sexuality
none
   - A module on sex
gender
sexuality
   - A whole course on sex, gender and sexuality

8.6 INTERVIEW SCHEDULE

1. As a counselling psychologist, how do you see your role?

2. What is your understanding of sex and sexuality?
   (prompts: eg. such as words, activity, behaviour, expression)

3. What do you think has influenced your understanding of sex, both formal and informal?
   (Prompts can include: sex education, supervision, training, childhood experiences and parental/family influence – also point out that they must pick the level they feel comfortable talking about this at, and have the right not to answer it).

4. What role does sex have in therapy?
   (Prompts: Should sex be a topic you can talk about? Would you bring it up if a client does not? Would you specialise in psychosexual therapy – if yes/no, why?)

5. How have you worked with sexual issues and what was your experience of that?
   (Prompts: emphasise preserving confidentiality of clients; what feelings and issues topic raised. Theoretical issues. If they have not had experience of clients talking about sex or sexuality, invite them to talk about what reasons may be for that?)

6. What further training, if any, do you think would be helpful?

7. Having come to the end of the interview, would you like to change or add anything to how you see your understanding of sex and sexuality?

8.7 PARTICIPANT DEBRIEF INFORMATION

Debrief Information

Thank you for giving up your time and taking part in this research.

This research is aimed at understanding how psychological therapy practitioners understand sex and sexuality. This will incorporate an exploration of what influences learning about sex and whether attitudes to sex and sexuality influence how and what can be spoken about with clients. It will also consider what therapists feel is regarded as important in relation to working with sex and sexuality in the therapy room.

Should anything difficult arise from your interview with me, either now or subsequently, in the first instance, please do utilise your own supervisory support. You can also contact me (the researcher) or if you feel more comfortable, you can contact my Director of Studies or the Head of the Department.

Researcher contact details:

Anu Kumar
Roehampton University
Department of Psychology
Whitelands College
Holybourne Avenue
SW15 4JD
kumara@roehampton.ac.uk

Below is a brief list of counselling and training organisations. Should you require any further information on specific issues arising from the interview or related to the research topic, please do not hesitate to contact me.

Thank you again for your time.

Anu Kumar

Director of Studies Contact Details:
Lyndsey Moon
Roehampton University
Whitelands College
Holybourne Avenue
SW15 4JD
lyndsey.moon@roehampton.ac.uk
020 8392 5773

Head of Department Contact Details:
Diane Bray
Roehampton University
Whitelands College
Holybourne Avenue
SW15 4JD
d.bray@roehampton.ac.uk
020 8392 3627

Counselling and training organisations

College of Sexual & Relationship Therapy (formerly British Association. of Sexual & Relationship Therapy)
Provide training in psychosexual and relationship therapy, including a list of courses they accredit. Also provide a database of trained psychosexual and/or relationship therapists.
Tel: 020 8543 2707 Email: info@cosrt.org.uk Website: www.cosrt.org.uk

Relate
Counselling service for adults with relationship problems. The nearest branch is listed in the phone book or look at the website.
Tel: 0845 456 1310 Website: www.relate.org.uk

Pink Therapy
Gender and sexual diversity counselling training. Also provide a database of gender and sexual diversity therapists.
Tel: 020 7434 0367 Website: www.pinktherapy.com

British Psychological Society
Tel: 0116 254 9568 Email: enquiries@bps.org.uk Website: www.bps.org.uk

United Kingdom Council for Psychotherapy
Tel: +44 020 7014 9955 Email: info@ukcp.org.uk Website: www.ukcp.org.uk

British Association of Counselling and Psychotherapy
Tel: 01455 883300 Website: www.bacp.co.uk

8.8 RESOURCE BACK UP INFORMATION FOR PARTICIPANTS:

Resources

Help after rape and sexual assault:

NHS guide for men and women who have experienced sexual assault or rape, including details of sexual assault referral centres:
http://www.nhs.uk/Livewell/Sexualhealth/Pages/Sexualassault.aspx

National Rape and sexual abuse helpline: 0800 802 9999
Open: 12-2.30pm and 7-9.30pm every day of the year. Provides support for male and female survivors, their partners, families and friends.

Survivors UK - http://www.survivorsuk.org/
Helpline: 0845 122 1201 (Mondays, Tuesdays & Thursdays, 7pm-9.30pm).
Offers support, advice and counselling to men who have experienced childhood sexual abuse or rape.

Rape Crisis
Links to rape helplines and crisis groups around the UK.
Email: info@rapecrisis.org.uk Website: www.rapecrisis.org.uk

Domestic Violence

National Domestic Violence Helpline – collaboration between Women's Aid and Refuge: 0808 2000 247 – open 24 hours a day.

Broken Rainbow:
For lesbian, gay, bisexual, and transgender people experiencing domestic violence.
0300 999 5428- Open: Monday and Thursday, 2-8pm. Wednesdays, 5-10pm.

Men's Advice Line:
http://www.mensadviceline.org.uk/mens_advice.php
For men of all sexual orientations who are experiencing or have experienced domestic violence. 0808 801 0327. Open: Mon – Fri 10am-1pm and 2-5pm.

Sexual Anatomy

Male

http://www.uic.edu/depts/wellctr/ltas_anatomy.shtml

Male Health - malehealth.co.uk
Run by the Men's Health Forum, this site provides information about the key health issues affecting men.

Female
http://www.3dvulva.com/

http://www.the-clitoris.com/f_html/anat_indx.htm

Sexual Health

Sexually Transmitted Infections
http://www.nhs.uk/Conditions/Sexually-transmitted-infections/Pages/Introduction.aspx

Sexual Dysfunction Association
Advice and help for men affected by impotence (erectile dysfunction) and their partners.
Helpline: 0870 774 3571 Email: info@sda.uk.net Website: www.sda.uk.net

Counselling and training organisations

College of Sexual & Relationship Therapy (formerly British Assoc. of Sexual & Relationship Therapy)
Provide training in psychosexual and relationship therapy, including a list of courses they accredit. Also provide a database of trained psychosexual and/or relationship therapists.
Tel: 020 8543 2707 Email: info@cosrt.org.uk Website: www.cosrt.org.uk

Relate
Counselling service for adults with relationship problems. The nearest branch is listed in the phone book or look at the website.
Tel: 0845 456 1310 Website: www.relate.org.uk

Lesbian, gay, bisexual, transgender and queer

Albany Trust - www.albanytrust.org
Provide psychosexual and relationship counselling for all sexualities and genders.

Pink Therapy – www.pinktherapy.com
Database of lesbian, gay, bisexual and transgender therapists and run workshops on working with sexual minority clients.

http://www.aglp.org/gap/4_psychotherapy/
Aimed at psychiatrists, though very relevant to psychologists and therapists, this website gives an introduction to some of the key issues when working with LGBTQ clients.

Disability

Outsiders - www.outsiders.org.uk
Sex and relationship resources for disabled people (with information about the Outsiders Club) Email: info@outsiders.org.uk

TLC Trust - www.tlc-trust.org.uk
Provides information, advice and support for disabled men and women to help find appropriate sexual and therapeutic services.

Sexual Health and Disability Alliance - http://www.shada.org.uk/?q=node/7
Information for health professionals in relation to disability and sexuality.

Health

MS Trust- www.mstrust.org.uk
A free downloadable guide called 'Sexuality and MS: a guide for women

Vulval Pain Society- www.vulvalpainsociety.org
UK based information on the vulva, and vulval pain conditions.

Books/Journal Articles

Bancroft. J. (2009) *Human sexuality and its problems*. Edinburgh: Churchill Livingstone.
Guide to human sexuality and its related isssues.

Butler, C., O'Donovan, A. & Shaw, E. (Eds, 2010) *Sex, Sexuality and Therapeutic Practice*, London: Routledge.
Good basic guide to some of the issues that can arise when working with clients with sexual issues.

Connan, S. (2010) A kink in the process. *Therapy Today. Vol* 21 (6) July.
http://www.therapytoday.net/article/15/52/categories/

Davies, D. (1996) Pink *Therapy: A guide for counsellors and therapists working with lesbian, gay and bisexual clients*. Berkshire: Open University Press.

Davies, D. (1996) *Pink Therapy: Therapeutic Perspectives on working with lesbian, gay and bisexual clients*. Berkshire: Open University Press

Denman, C. *Sexuality: A biopsychosocial approach*. Basingstoke: Palgrave Macmillan.

Easton, D. (2010) Cultural *competence with BDSM Lifestyles* in: Moon, L. (Ed) Counselling Ideologies. Farnham: Ashgate.

Robinson, K. (2005) Queerying Gender: Heteronormativity in early childhood education. *Australian Journal of Early Childhood. Vol. 30* (2), p19-28

Stewart, E. G. & Spencer, P. (2002) *The V Book: Vital facts about the vulva, vestibule, vagina and more*. London: Piatkus.

Zildbergeld, B. (1999) The New Male Sexuality. New York: Bantam Books.

Journals

Sexual and Relationship Therapy (formerly Sexual and Marital Therapy).

Sexuality and Disability

Sexualities

8.9 TRANSCRIPT EXTRACT

Emergent themes	Transcript	Initial thoughts
Uncertainty of meaning External locus of meaning? Curiosity. Uncertain Not knowing? Grasping for ideas. Sex crude Sexuality – gentle. Sexuality – types. Uncertainty.	And what would you say your understanding of sex and sexuality is? I: I think that the first thing is that... I'd seen that question and I was going to s... I... Yeah, I could have gone on the Internet and just had a look [laughing] but I haven't. Erm, and just was interested that you've put those two there. Sex and sexuality. And I kind of pa... found myself thinking are they the same or are they different and why did you put both of them there? So I sort of found myself thinking of that and, erm, (.3) decided that I don't quite know actually what the actual differences are and I thought maybe, erm, (.3) had a fleeting thought but nothing kind of formed, erm, er, what the differences are or what they are. I kind of thought maybe sex was sort of more a crude way of putting something and the sexuality felt much more kind of gentle way of... of naming similar area. That's what I was thinking in my head, erm, and maybe, you know, there are different types of sexualities as well. Erm, maybe sex is sort of more, erm, naming the area and sexuality is a sort of different types of sexualities. I don't... I don't know. Don't know... Didn't come... I didn't sort of like think what's the difference, erm, (.2) so I don't, to be honest, I don't know what's the difference/R: Hm-mm./Yeah. So what's the difference then? Are you able to tell me or...? R: Yeah. Erm, (.2) so you would say that sex is more a crude description of...	Unsure about meaning *for self?* Wanted and could have searched for external definition, but didn't. **Interested** – *curious about links between sex and sexuality.* Realised uncertain – **don't quite know** re sex and sexuality differences. *Where does that leave her?* **Fleeting** thought on differences. *Hard to grasp?* Sex **- crude** Sexuality – **gentle, naming similar area.** *Area denoting subject and/or anatomy?* Sex – naming area and sexuality – different types of sexuality. **Don't, I don't know, Didn't come, didn't sort of like... don't.** *Uncertainty, lots of don'ts.* *Looks to me to tell her. Feels uncertain of her own convictions, own thoughts?* *I try to encourage her to explore...*

	I: Yeah.	
	R: ... a particular act or...?	
More than just intercourse.	I: Yeah. Like a sexual act or intercourse. Or not necessarily intercourse but sexual act... act between two people, erm, (.2), yeah. I think that that’s probably what I was thinking. Yeah./R: Mm/While sexuality is kind of more, erm, (.4) it’s... it’s... kind of feels a bit more fuller than that. It’s... It kind of...	**Sex not necessarily intercourse, but sexual act between two people.** **Sex is sexual acts.** **Sexuality – fuller**
	R: A bit more...?	
Sexuality related to feelings. Meanings uncertain. Sex and sexuality not easy to distinguish. Multiple meanings?	I: Fuller. Sort of there’s something else about it than just the act, in a way. Erm, (.3) it’s... the... there’s sort of something about, erm, the gender bit in this and kind of my approach to... to sex in it or er, the body. ‘Cause, you know, the kind of erm, erm, that, you know, the, like more kind of in the sort of tantric type scenario, erm, that there is not only the kind of, er, the very genital type thing but it’s sort of more fuller bodily thing. But, you know, that’s sort of what I’m thinking. There’s gender bit in it and, erm, erm,... and kind of maybe understanding that the different types or, erm, (.2) different people have different approach or... I don’t know. That’s just sort of my... that’s where my thoughts are going but... but I actually haven’t for myself thought of, erm, erm, (.3) you know, what are the differences here, you know. It’s just more kind of a feeling difference rather than I kind of know. But what... what would you say to that? How... How would you... Am I in the right direction or what’s your sort of sense?	*Very confused and vague...* *Gender – her own approach link with sex & the body.* *Acknowledges sex not always driven by genitals more* **fuller bodily thing.***spiritual?* Tantric – spiritual/psychological. Makes slight connection with gender. .. vague.. *different approaches... different types of activity Femininity?* *Hasn’t thought before of differences. New to her.* *Touches on many possible meanings and seems not sure which is ‘right’. All could be linked.* **Feeling difference.** *Turning to me, seeking*

Seeking clarification Confusion.	R: You bring... What you're saying is... is your... what you understand it to be. I: Hm-mm. R: And I don't want to impose my... I: Yeah. R: ... understanding of that. Erm, (.3) so, erm, but the... one of the things I would think of/I: Yeah/with sexuality would be about how... about expression. I: Right. Yeah. Yeah. R: Erm, because it's more than just sex. Because it's kind of like they are linked and they are intertwined/I: Mm/in... in some sense. Erm, and that's what I was thinking of more. But...	*reassurance that she is on the right lines.* Sexuality linked to expression. *I attempt, rather clumsily to give cue words, but try not to say to what extent. Perhaps I should have held back here? I get the sense she knows more than she realises, but feels stuck.* *She is checking understanding here. Uncertain of her own definitions...*
Power of female sexuality. Sexuality a social process.	I: Yeah, sort of like how it is expressed, you mean. How in terms of, erm, (.5) kind of how... how the sort of sexual feelings are expresses toward... towards oneself or somebody else or... in... in... in the context of sexual act or in context of, er, you know, you know, a young woman dressed in a very kind of provocative way. Would that be sort of there as well or...? You know, for example, I don't... I don't know, you know. R: Erm, that could be one of the ways.	*Searching for further meanings. My input seems to help her make connections. Though still very uncertain.* *How sexual feelings expressed towards self or others, during sex, or through social interaction. Touches on power of female sexuality. I find myself curious to know her background and looking forward to exploring that to see whether her understanding becomes clearer.* *Seeking to reassure her.*