Navigating the frontier: A grounded theory study of how therapists address sexuality in therapy.

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Abstract

Background

Human sexuality is a highly debated topic in the social sciences and psychology. Counselling psychology has contributed to the body of knowledge by publishing guidelines on sex-affirmative practice, but little is known about what happens in the therapy space. Much research on best practice seems to be based on assumptions, rather than what is happening on the ground. Existing studies tend to focus on patients' experience of therapy, highlighting specific issues related to gender and sexual orientation. A review of the existing literature suggests a gap in the knowledge of how therapists address sexuality in sessions, especially using a qualitative methodology.

Aim

This study aimed to understand and build a grounded theory of how psychological therapists address sexuality in therapy.

Method

Ten psychological therapists, all working in Greater London, participated in this study. Two identified as male and eight as female; six identified as heterosexual, one as omnisexual, two as gay and one did not disclose. In terms of professional registration, three were Counselling Psychologists, one Forensic Psychologist, three Clinical Psychologists, one CBT therapist, one Systemic Family Therapist and one Psychotherapist. Regarding preferred model of practice, three participants described working integratively, one pluralistically, three espoused CBT principles, two psychodynamic and one systemic. All participants were between the ages of 30 and 59 and five identified as white British, two as White Other, one as Black British and another as Asian British. Intensive individual interviews were used, and the data

were treated according to constructivist grounded theory guidelines, as advised by Charmaz (Charmaz, 2014; Charmaz & Henwood, 2017).

Findings

Sexuality remains a largely unknown and unexplored frontier in the field of therapy. Acknowledging its significance for identity and well-being, therapists must navigate their own personal and clinical experiences of sexuality to address it with clients. Curiosity is first ignited in personal experiences and is subsequently honed through training or, in its absence, clinical experience. This is the exploration of uncharted territories, providing opportunities for growth and development while simultaneously causing anxiety and discomfort. Best practice guidelines and available social-cultural signs and practices function as a map, leading them through their work. However, these maps are frequently incomplete, unclear or conflicting, creating further uncertainty on how to proceed. In the therapeutic encounter, the client is the captain of their journey, with therapists co-developing the necessary tools and individual meanings through language. Feelings of shame and discomfort often act as barriers to exploring sexuality, for both therapist and client. However, supported by a therapeutic relationship that fosters collaboration, it is possible to navigate the frontier of sexuality in a healthy, meaningful, and affirming manner. This study draws upon cultural-historical and activity theories (CHAT) to build upon therapists' experiences and puts forward a model of addressing sexuality that goes beyond Cartesian arguments and model tribalism. By bringing together every day concepts grounded in participants experiences and scientific concepts provided by psychanalysis and CHAT, this theory highlights areas for further development while providing a working model for training and practice, thus contributing to the Counselling Psychology agenda of pluralism and social justice.

Keywords: sexuality, therapy, psychological therapists, counselling psychology, grounded theory, cultural-historical and activity theories.

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Chapter 1 – Literature

1.1 - Introduction

Sexuality as a topic has fuelled artists' and philosophers' thinking and work over the centuries, and there is no indication of stopping. Michel Foucault (1926 – 1984) advocated that sexuality and desire are the truth of our being (Foucault, 1978, 1984). However, is it the truth of our psyche?

The literature suggests that "sex remains a difficult subject to discuss with any sense of balance" (Denman, 2003, p.1). This might explain how strongly people feel about the topic and how complicated it is to conduct research. Sexuality is intertwined with politics, religion, culture, biology, and all other areas of life, meaning that even finding a single definition can prove problematic.

There are many different ways to look at sexuality, but to keep this chapter organised, we will talk about it briefly from a historical point of view, focusing on biology and medicine; social aspects and sociology, including law, religion, and moral issues; psychology, with a focus on counselling psychology (CoP); and finally, what we currently know about sexuality and therapy. Sex, as biological gender and behaviour (Landers & Gruskin, 2010) is included in the wider term of sexuality, unless clearly stated otherwise. The acronym LGBTIQ (Lesbian, Gay, Transsexual, Intersex, and Queer) will be used because of the researchers' agreement with the reasons provided by S. J. Ellis et al. (2019) for using this acronym, except when referenced authors use other terms. Some authors, such as Arnold and Brewster (2017) advocate that the acronym should remain as LGB to avoid "conflation of all sexual minority concerns" (p.234). Therefore the acronym GSRD (Gender, Sexuality and Relationship Diversity) will also be used as proposed by Silva Neves and Dominic Davies ('ABOUT PINK THERAPY', n.d.; Neves, 2023; Neves et al., 2023a, 2023b; Neves & Davies, 2023). The use of "therapist" and

"practitioner" includes psychologists, counsellors, and psychotherapists, involved in talking therapies.

1.2 - Reflective Statement

To introduce myself, I am a cisgender, heterosexual woman, in a long-term monogamous relationship. These elements make up my sexuality, are a product of my development, and form part of my identity.

Making sense of sexuality has been a compelling journey, and in this reflection, I will try to be as clear, concise, and true to myself as I can be. When I started this project, my first step was to reflect on my interest in sexuality. So, I went back to the first time I became aware of what sex was, and during that process, I recovered memories of sexual abuse during my childhood. Undoubtedly, my interest in sexuality and sexual practices has been a way to make sense of this experience, perhaps unknowingly adopting an attitude of traumatophilia (see (Saketopoulou, 2014, 2023; Saketopoulou & Pellegrini, 2023).

Although I had personal therapy in Portugal and again in the UK, I was never asked about my sexual history or well-being, despite thoroughly addressing other aspects of my upbringing, identity, and relationships. As I consider further in this literature review, it may be that certain models of therapy are less open to sexuality, or perhaps that the gender, cultural, and religious background of therapists may play a role. Certainly, my history as a survivor of sexual abuse impacts how I approach sexuality in therapy, which led me to wonder how other therapists think, feel, and approach this theme.

I probably first became aware of sexuality around 4 or 5 years of age. At that time, the physical differences between boys and girls were the main interest, which reflected the prevalent cis, heteronormative attitudes to gender at the time. In my teenage years, my attention moved towards body changes and pleasurable sensations. Simultaneously, I became aware of

what was expected of me as a heterosexual woman and often felt pressure to conform to certain cultural norms associated with my Christian, conservative upbringing. This is consistent with what some authors describe as the pressure to conform to gender, sexual orientation, and relationship roles (Ellis et al., 2019).

During my early formal education, sexuality and human relationships were addressed either from medical or moral perspectives. For many years, the only space to address these topics was the Moral and Christian Religion class, which only condoned heterosexual, monogamous sexual relationships. At this time, sexual education in Portugal advocated abstinence, while birth control and abortion were frowned upon, and same-sex relationships were labelled as sinful or unnatural. Regardless of how biased those learning experiences might have been, given my curious nature, attending these classes paved the way for my discoveries of sex and sexuality. This fascinating process has rarely been experienced without feelings of doubt, shame, guilt, and all too often, uncertainty.

By the age of eighteen, I became increasingly aware of the gender stereotypes and prejudices I was brought up with and viewed going to university as moving towards a more liberating experience of life and sexuality. Although this was somewhat true on a personal level, I felt that sexuality in the Coimbra University psychology course was taught within a dismissive heteronormative and sex-negative framework. The topic was rarely discussed, and when it was, it was usually from a biological or moral point of view, focusing on sexual dysfunction and treatment rather than identity, development, pleasure and wellbeing. The focus was on the relationship between sexual trauma, mental illness, risk behaviours, sexually transmitted infections (STI), gender, and sexual orientation (from the perspective of illness or deficiency). I concluded my studies in 2007, and I know that more attention is now paid to gender, relationships, and sexuality from an affirmative stance; however, religious and moral views still prevail.

In the postgraduate course that I enrolled in the following year, sexuality was discussed as an integral part of people's lives, diverse and natural, and possibly as a source or sign of psychological distress. Following our initial lectures on the topic, my colleagues and I felt that sexuality had started to emerge more in our sessions. We attribute this result to our openness. Clients suggested that direct questioning was a major factor in allowing them to express their sexuality and normalise their experiences. The training and practice were based on psychoanalytic and cultural-historical theories and until I started this research project, I assumed that sexuality was an integral part of those disciplines, which retrospectively seems naïve.

The Portuguese colleagues I remain in contact with often express frustration regarding the lack of learning opportunities in sexualities, assuming the UK, being more diverse and culturally advanced will provide those opportunities. This inspired me to reflect on my experience as a practicing psychotherapist and trainee. In the early stages of my training as a counselling psychologist, I felt underprepared to address sexuality with clients. Unfortunately, after years of research and near completion of my degree, I cannot say that I am completely confident due to a lack of training and experiential opportunities. In addition, I think that the environments in which I had placements might have contributed to the absence of sexual topics in therapy. These strongly relied on cognitive behavioural therapies, which focus on thinking, behaviours and diagnosis specific but universally applicable, leaving little space for individual exploration of identity. The only placement where I saw therapists openly discussing sexuality was in a substance-use service in 2020, however this undoubtedly from a perspective of risk, illness and deviance. All these training experiences left me with an eerie sense that sexuality was still a taboo or unwelcome topic in psychological intellectual settings and clinical practice. Interestingly, my initial review of the literature was marked by confusion about why there were

so many books and theories about sexuality and how to address it but limited research on clinical practice and training, especially from Counselling Psychology in the UK.

In my experience with personal therapy, sexuality was mostly absent from sessions too. I found this odd, given how important I felt sexuality to be in my own life. After discussing my history of abuse, other areas of sexuality, such as pleasure and health are still not discussed often, perhaps because of the avoidance of both my therapist and me. My student peers and work colleagues suggested that sexuality was not a part of their therapy either. Several were surprised at how sexuality seems to be irrelevant in therapy in contrast to its importance in social environments, including the media. This led to the initial research question of whether sex was addressed in therapy and how so. Although a lot has been written recently about LGBTIQ's experiences of therapy, I felt that my own cis, hetero, and monogamic sexual development was not thought of and if so from a perspective of normality, neglecting the individual constructions that each of us does of their own sexuality. Not dismissing how GSR diverse people face their very own specific issues such as discrimination and invisibility or how much our profession needs to do to create equitable, affirmative and inclusive therapy. My literature review was nevertheless focused on finding definitions and working models of sexuality, thereby normalising and affirming all experiences of sexuality. Unfortunately, this fell on the same pitfalls that I wanted to avoid, namely by keeping sexuality split between biological, social and psychological perspectives and relying on theoretical works given the lack of research available.

I hope that it has become clear how my personal and professional experiences shaped my interest in sexuality and how I became increasingly interested in the actions and processes underlying therapist's practical approaches to this aspect of human life. I will now review relevant literature for my research, highlighting the research questions that arose in the process.

1.3 - Sexuality: definition and history

Although much has been discussed about sexuality, a quick search of the dictionary shows the difficulty in defining the term. It seems to be related to the quality of being sexual, pointing towards an ability to experience and show sexual feelings, attributes, and actions related to sex (Oxford English Dictionary, n.d, Cambridge English Dictionary, 2023). So, what is sex?

The term sex was first used in the sixteenth century and refers to the biological difference between males and females. In the nineteenth century, with the advent of biology and positivism, the term sexuality was introduced with reference to the quality of being sexual (Denman, 2003; Weeks, 2017). This is not a definition but points towards what has been historically thought to be sexual.

Jeffrey Weeks (2017) concludes that there is no answer to the question of what exactly constitutes sexuality. The only thing authors seem to agree on is that it is a complex, diverse, and dynamic concept with many different and changeable meanings for individuals and societies (Butler et al., 2009; Denman, 2003; M. L. Ellis, 1997; Milton, 2010; Richards & Barker, 2015; Weeks, 2017).

The World Health Organisation defines sexuality as:

"…a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors" (WHO, *Defining Sexual Health*, 2006a)

Some authors, like M. Milton (2014) advise that making assumptions about sexuality can be reductionist. Therefore, in this thesis sexuality was considered in its wide, complex, and dynamic meaning so that therapists could input their own understanding and experiences.

The next sections of this chapter discuss how different fields and perspectives conceptualise and research sexuality. It also discusses how these ideas may be connected to how therapists might address sexuality in therapy with a critical review of the limited empirical evidence related to it.

1.4 - Sexuality, biology and medicine

Despite the difficulty in identifying and separating the qualities of sexuality, no author denies biology to be an inherent part of it. As mentioned, sex and sexuality were introduced to describe the binary categorisation of natural gender. As Denman (2003) summarises: "Biological sex has several subcategories which include chromosomal sex, hormonal status, internal sexual organs, external sexual organs, and 'brain sex' (p.10). These aspects of biological sex will only be discussed from the perspective of how they might influence therapists and therapy.

For centuries, sex has referred to the quality of being either female or male. This categorisation still finds its way into conversation about sexuality today, namely on what constitutes natural and normal sexuality (e.g. S. J. Ellis et al., 2019). Nineteenth century scholars, such as Richard von Krafft-Ebing's (1840-1902) and Sigmund Freud (1856 – 1939), suggested that there is an innate sexual drive or energy aimed at procreation and perpetuation of the species. Based on this view of sex, Kraft-Ebbing proposed the theory of "sexual inversion" where he suggested that desire for the same sex is the upshot of a congenital reversal in gender traits (Race, 2015). Freud's background was in medicine and some of his ideas are, closer to biomedical sciences and therefore philosophically essentialist (Denman, 2003;

Weeks, 2017). It is worth noting that those early 'sexologists' advocated that homosexuality, being innate, should not be the basis for discrimination. However, as the biological understanding of sexuality became increasingly mainstream, many ideas were appropriated and changed to fit religious and moral purposes such as conversion therapy (S. J. Ellis et al., 2019; Weeks, 2017).

This is a good example of how ideas in biology are still widespread in scientific debates about sexuality today. For example, at the time of writing the initial literature review, much media coverage was given to a study that established the inexistence of the "gay gene" (Genetics of Sexual Behavior – A Website to Communicate and Share the Results from the Largest Study on the Genetics of Sexual Behavior, n.d.). The media coverage of this study is striking, considering how long the search for the exact biological mechanisms of sexual orientation has been going (e.g. Hamer & Copeland, 1994). The other area where biology-focused research has been most prolific is gender. For example, the idea that men's and women's brains are different prevails, as do beliefs associated with gender roles and sexual orientation (Denman, 2003; Roselli, 2018; Rouse Jr & Hamilton, 2021). This will have a direct impact on psychological therapies (Butler et al., 2009) in same cases informing the development of gender and sexual orientation specific services and initiatives (e.g. Pink Therapy, *Practice Briefing - Psychological Interventions to Help Male Adults.Pdf*, n.d., The Maya Centre, Spectra London). One argues that although there might be benefits to these services and underlying theory, it perpetuates atomised thinking about sexuality, thus limiting therapists' access to a unifying theory of sexuality.

The works of Alfred Kinsey, who conducted a series of studies on human sexual behaviour with the aim of uncovering the sexual behaviours of average Americans (Richards & Barker, 2015), are still relevant for clinical practice today. Kinsey (1948, 1953) had a major impact on the understanding of sexuality; for example, advocating for a continuum between

poles of gender expression and sexual orientation. Every author concerning themselves with sexuality mentions his work (e.g. (Butler et al., 2009; Denman, 2003; Weeks, 2017), however S. J. Ellis et al. (2019) suggest that his ideas "never really catch on" (p.55) which is reflected in the current literature, apart from LBTIQ Psychology.

It is also important to mention William H. Masters and Virginia E. Johnson and how their work in the 1960s and 1970s supports the biological understanding of the sexual response cycle that is still used in behavioural sex therapy today (Daines & Perret, 2000; Richards & Barker, 2015).Their work was innovative because it focused on sexual functioning and pleasure, albeit prescriptive and mechanised in their views. Their work is still referenced as a basis to move away from models of illness, dysfunction, and 'normality' and into a sex positive, affirmative stance (Burnes et al., 2017b; Cerbone, 2017; Cruz et al., 2017; Darnell, 2015; Mosher, 2017). However, even in the field of sex therapy there are concerns that therapists perpetuate sex-negative themes where pleasure is not prioritised (e.g. Darnell, 2015) and one might add that the processes around sexuality are reduced to quantitative, static, purely biological variables.

The prolific use of diagnostic manuals, such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2013) and International Classification of Diseases (ICD), perpetuates a biological and normative understanding of sexuality. Albeit important developments such as the removal of homosexuality from the manuals and the ongoing discussions around gender dysphoria and intersex variation, they continue to follow an essentialist stance, where sexual acts, behaviours and feelings are linked "to internal physiological and psychological properties, rendering them a matter of individual constitution that may benefit from therapeutic intervention" (Race, 2015, para. 4).

Barker (2017) reflects on how these manuals arbitrarily define what is abnormal and unhealthy. By doing so, they continue to contribute to a sex-negative frame and the continuous

marginalisation of certain groups and practices. Although these manuals might be unhelpful (even harmful) in making sense of clients' personal experiences, they have given different professions (e.g. nursing, medicine, psychology, and social work) a common framework. In some cases, a biological perspective might even be inclusive, for example in supporting trans people's access to therapy and medical treatment (S. J. Ellis et al., 2019).

In one of the few manuals on training on sexuality (e.g. Butler et al., 2009), authors acknowledge the importance of biological ideas to practice and ask students and therapists to reflect on their views of sexuality, what they consider to be 'natural' and why. However, several authors suggest that these questions are not addressed in most training courses neither in the UK nor the US, across all psychological professions (Abbott et al., 2021; Mollen et al., 2020; Shaw et al., 2008, 2012; Wiederman & Sansone, 1999; Wright, 2022) with consequences discussed further.

Since the nineteenth century, the biological model of sexuality has prevailed, especially in sexual health (Denman, 2003; S. J. Ellis et al., 2019; Hargons et al., 2017). How do therapists work on sexuality from a biological standpoint?

1.5 - Sexuality and sociology

There is no prevailing theory in the field of sociology regarding sexuality, but most theories intersect politics, religion, and morality. This section focuses on a few that seem more closely related to sexuality and therapy.

"Sociologists are particularly interested in how social institutions shape, facilitate, and restrict various forms of sexual expression" (DeLamater & Plante, 2015, p.3). Social processes during the Enlightenment period changed the perception of sex from sinful to natural and medicalised (DeLamater & Plante, 2015; Denman, 2003; Hawkes, 2002; Štulhofer, 2015). During this period, the bourgeois class regulated sex with a moral distinction between the sex

of the upper classes, which is seen as disciplined and socially responsible, and the lower classes, whose sex is demonised and seen as dangerous (Denman, 2003). Those centuries saw a move away from religion-regulated sexuality towards an increasingly political one (Patu & Schrupp, 2017). This is important if we consider, for example, legislation around marriage, prostitution, and sex work. It is also important because, as in biology, it defines morality through the lens of what is natural and healthy. From the late nineteenth century to the late twentieth century, sociology was essentialist, as was psychiatry and socio-biology.

The 20th century saw sociology make a distinct contribution to changes to sexual paradigms. In the 1960s with feminism, 1980s with social constructionism and Queer theories in the 1990s.

Feminism has been understood as a problem of gender, embodiment, heterosexuality, and monogamy (Evans et al., 2011; Patu & Schrupp, 2017). No single feminist theory exists, but several have developed and changed over time. These theories can even be opposing, although most would present compulsory heterosexuality as a 'man-made institution' (Rich, 1980, p. 637) to maintain male control over society (Kitzinger, 1989; Kitzinger & Wilkinson, 1995; Wilton, 1995). According to feminist theories, heterosexual normative discourse discourages women from living their sexuality fully, maintaining them securely under the control of the patriarchal system (Ryden & Loewenthal, 2001). Women's bodies are often sexualised, existing for men's use and, institutions such as marriage and monogamy exist to maintain the subjugation of women. Feminism also exposed enduring colonialist ideas of ownership of another's body and the view of non-western people as close to nature, and therefore in 'need of civilising' (DeLamater & Plante, 2015; Patu & Schrupp, 2017; Ryden & Loewenthal, 2001).

Many of the recent guidelines on sexuality and therapy have been possible due to a shift in the understanding of sexuality, including the contributions of Queer theories. Queer

psychology posits an experience of self and identity that is socially constructed by language, in a process marked by fluidity, complexity and subjectivity, questioning and sometimes subverting prevalent social categories (Green, 2006). Some criticism of prevailing Feminist and Queer theories has been their westernised views. For example, Earp et al. (2022) discuss how the understanding of what constitutes a sexual act is a Western social construction and that other experiences have often been devalued or demonised. The same is true for the experiences of the non-normative groups.

One cannot discuss sexuality from a sociological perspective without referring to the seminal work of Michel Foucault in 1981, which is intrinsically linked to major theoretical frameworks in the sociology of sexuality: socio-constructionism and queer theory (Dallos & Draper, 2015; DeLamater & Plante, 2015; Green, 2006). Foucault challenged the idea of repressed sexuality, advocating that an individual's expression of sexuality is both a product and construction within well-defined structures of power (Foucault, 1978, 1984). With the social construction of sexuality and therapy (Dallos & Draper, 2015; Gergen, 2022) discourses based on suppression and religious morality (Jule, 2015) seem to have been abandoned in favour of discourses on hygiene, health, and neo-liberalism (Weeks, 2017). The author alongside Denman (2003) and S. J. Ellis et al. (2019) suggest that these discourses seem to encourage a personal exploration and expression of sexuality, while at the same time continuing to regulate and capitalise on it.

Some of the structures of power that Foucault stresses are still relevant today. S. J. Ellis et al. (2019) highlights how religious and conservative moral views have led to discrimination against LGBTIQ people, including persecution, arrests, and death (for example, Tanzania, Egypt, Malaysia, and Russia). In Europe and the US, while some countries have passed laws to increase equality, others are seeing the rise of right-wing conservative governments, whose research has shown to be linked to the withdrawal of LGBTIQ rights and an increase in hate

crimes (Moreno et al., 2019). Equally, sexual rights and equality have been hailed as "wokenism" and its dangers extorted (e.g. Brandon & Simon, 2020). As Weeks (2017) states: "institutionalized forms of homophobia, transphobia and biphobia have proved powerful weapons for building political constituencies for conservative and new forms of nationalism" (p.197).

This matters to therapists because people's experiences of sexuality are shaped, and in turn, shape the social context, although since Foucault, the social sciences seem to have followed a more deterministic and idealist view of sexuality. (Butler et al. (2009) emphasised the importance of therapists reflecting on their own and their clients' cultural and social norms. Is this occurring in practice? How do therapists navigate cultural norms different from their own? Do they adopt Queer, Feminist or socio-constructionist views in their work, and how?

No academic would dismiss the importance and interplay between biology, sociology and psychology (Butler et al., 2009; Denman, 2003; S. J. Ellis et al., 2019; Richards & Barker, 2015; Weeks, 2017) and we will now look at the latter.

1.6 - Sexuality and Psychology

Psychology influences sociology and biology and is in turn influenced by them. As a discipline, it has been a major contributor to the understanding and treatment of sexuality for many years.

It is impossible to discuss sexuality in psychology without mentioning Freud (1856-1939) and psychoanalysis. Freud brought sexuality to the forefront of psychological thinking. Lemma and Lynch (2015) describe how Freud emphasises early experiences and interpersonal relationships as fundamental for the development of the mind. Hence, sexuality is an intrapsychic experience, as much as it is behaviour and enactment. Freud established the "normative abnormality of sexuality" (intro), suggesting that 'normal' sexuality always

encompasses perverse aspects. Importantly, Freud underlined that sex is biological, developmental, and emotional, which relies on intrapsychic aspects such as libido, instinct, and drive (Blass, 2016; Denman, 2003; S. J. Ellis et al., 2019; Lemma & Lynch, 2015).

Freud suggested that individual and intrapsychic drives try to find expression in the environment, but if one wants to be accepted, those drives need to be repressed, resulting in neurosis.

For years, partly because of the complex and often contradictory nature of Freud's theories, the primacy of sexual drive for personality development and psychopathology gave place to other formulations (Denman, 2003; Weeks, 2017). For example, Karl Jung (1875-1961) focuses on libido as a source of curiosity and motivation, while English analysts tend to focus on relationships and intimacy (Denman, 2003).

There is intense debate about the role of sexuality in psychoanalysis and other therapeutic models. Fonagy (2009) highlights several reasons for the absence of psychosexuality in psychoanalysis, namely:

> its close connection with a problematic drive theory, the unconscious resistance and/or conscious prudishness of psychoanalysts, (c) the Kleinian tendency to reduce psychosexuality to the earliest libidinal stages, (d) the increased proportion of psychoanalytic patients with borderline psychopathology for whom sexual interpretations are unhelpful, or (e) the incompatibility of an object-relations theory based on the observation of mother-infant interaction and drive-theory accounts leading to a tendency to reduce sexual material to a presumed underlying relationship-based pathology (p.6).

Fonagy, like others, suggests that English, French, and American psychoanalysts have different attitudes towards sex and sexuality (Fonagy, 2008; Fonagy et al., 2009; Lemma & Lynch, 2015; Saketopoulou, 2014). For example, Jean Laplanche (1924–2012) is often cited

in modern psychoanalytic works on sexuality as an alternative to more relational and perhaps conservative ideas on sexuality (Atlas, 2013, 2015, 2018; Saketopoulou, 2014, 2023; Saketopoulou & Pellegrini, 2023). Might these different attitudes influence therapists working in the UK, especially with London being a multicultural hub? In general, are these modern psychoanalytic views readily applied by therapists?

Regardless of the many misconceptions, interpretations, and developments, psychoanalytic theories have firmly maintained sexuality in the minds of people through pop culture while at the same time keeping it "repressed", perhaps because some of the terms became so ubiquitous (Fonagy et al., 2009; Saketopoulou & Pellegrini, 2023). Thanks to psychoanalysis, it is generally accepted that sexuality follows individual developmental lines, and that early sexual trauma has an impact on adult personality (Denman, 2003) with authors like Saketopoulou (2014, 2023) advocating trauma as transformative and crucial in sexual identity.

Freud suggested that people are born with innate bisexual feelings, but homosexuality is a deviation of sexual objects and behaviour (Denman, 2003; S. Freud, 2005), ideas which illustrate Freud's struggles to make sense of sexual orientation. Albeit placing libido and sexual drive at the core of psychic development, Freud suggested that "masturbation and oral sex to be immature forms of sexual expression" (Butler et al., 2009, p.14) Contemporary analysts still struggle with the nature of sexual orientation, and until recently a good therapeutic outcome was a heterosexual, patriarchal one (Denman, 2003). This was the case in every school within psychoanalysis, perhaps more so in the ideas of Melanie Klein (English tradition), Joyce MacDougall (French tradition) and Otto Kernberg (American tradition) (Blass, 2016; Denman, 2003). Those psychoanalytic ideas also contributed to legitimising homosexuality as an illness and conversion therapy as treatment (S. J. Ellis et al., 2019; Lemma & Lynch, 2015). Although this is no longer the case in diagnostic manuals and conversion therapy has been outlawed in

many countries, have these ideas vanished from therapy? Martin Milton (2014) suggests that, as late as 2009, some psychoanalysts still considered homosexuality to be "sub-optimal" if not pathological despite the attempts of many psychoanalysts to 'normalise' it.

Psychoanalytic sexuality has found its way into sociology, as Anthony Giddens (2013) concisely explains, and has also contributed immensely to how sexuality is approached psychologically. Feminist analysts such as Chodorow, Benjamin, Orbach and Eichenbaum brought feminist politics into the therapy room (Denman, 2003; Giddens, 2013), but has it stayed? And how?

More recently, psychoanalysts Galit Atlas (2013) and Jessica Benjamin (2015) have put forward new theories of sexuality introducing concepts such as "too muchness". Notwithstanding the usefulness of these concepts and others, they are theoretical assumptions illustrated with case studies chosen to fit the model. Peter Fonagy, Mary Target and Allessandra Lemma also suggested new developmental and relational theories of sexuality and illustrated how these can be used to inform clinical practice. However, these are theoretical ideas for which there is limited empirical evidence, albeit that not being the primary goal of psychoanalysis. Moreover, they may remain somewhat inaccessible to most psychologists who are not necessarily trained or specialized in psychodynamic psychotherapy.

The situation is not so different within the existential model with Professor Martin Milton and collaborators being the exception (Milton, 2010, 2014a, 2014b). However, these works remain theoretical, and it remains uncertain whether they are making their way into practice.

Another area where literature has been prolific in recent years is LGBTIQ psychology and GSRD psychotherapy. S. J. Ellis et al. (2019) explain that:

> LGBTIQ psychology, sometimes known as the psychology of sexualities, is a field of psychology that aims to challenge the primary and often normative focus on

> heterosexual cisgender people within society more broadly and academic research specifically. LGBTIQ psychology also provided a range of affirmative psychological, psychosocial and sociological perspectives on the lives and experiences of lesbian, gay, bisexual, transgender, intersex and queer people (p.4).

As the authors argue, it would perhaps be more useful to refer to psychologies given the diversity and the multiplicity of disciplines in the definition itself. In that sense, the authors will argue that LGBTIQ psychologies are applicable to working with everyone.

Gender, Sexuality and Relationship Diversity (GSRD) is a more recent acronym developed by Dominic Davies and the Pink Therapy Psychotherapy Service. According to Davies and Neves (in Hanley et al., 2023) the concept was born from the need to capture the different genders, sexes, sexual orientations, sexual behaviours, and relationships without continuously adding more letters to the LGBTIQ acronym. This term was also aimed at dispelling normative myths that only (or mainly) LGBTIQ people have mental health issues or require counselling. Therefore, GSRD applies to everyone. As Barker (2017) stresses both these terms and the ways we experience and discuss sexuality are culturally, socially and historically specific, in this case, to the United Kingdom and interrelates with particular narratives of colonialism, race, class and disability.

The developments highlighted above led to the publication of guidelines from professional bodies, such as the American Psychological Society (APA), British Psychological Society (BPS), and British Association of Counselling and Psychotherapy (BACP), on good practice in addressing sexuality in therapy. This and several recent works from different therapeutic modalities indicate a move towards relativist, pluralistic, sex-positive, inclusive and affirmative approaches, however, the question of how these approaches are reaching clinical practice remains.

Although S. J. Ellis et al. (2019) hope that LGBTIQ sexuality is covered in psychology courses, that does not seem to be the case (Abbott et al., 2021; Canvin et al., 2023; Dyer & Das Nair, 2013; Giami & Pacey, 2006; Shaw et al., 2008; Wiederman & Sansone, 1999; Wright, 2022).

As seen so far, this is not due to a lack of psychological theories or guidelines (e.g. Butler et al., 2009; Das Nair & Butler, 2012; Richards & Barker, 2015; Shaw et al., 2012) with discomfort and paucity of resources often being named as culprits. As seen in the final chapter, perhaps what is lacking is a unified way of addressing sexuality that could help abate some of the discomfort experienced by therapists and institutions while allowing for historical, cultural, biomedical and psychological shifts in the understanding of sexuality.

This section introduces psychology's engagement with sexuality, and the next two sections build on this relationship.

1.7 - A special reflection on Counselling Psychology (CoP)

This thesis is in the context of a professional doctorate in CoP, hence needing to discuss sexuality from that specific discipline perspective.

As mentioned in the reflective statement and below in this section, one of the prompts for this research project was the apparent lack of research available. In fact, one of the issues highlighted in the review of the literature is the amount of theoretical and conceptual articles and books and lack of research qualitative or quantitative research, especially within CoP. Looking more closely at the studies mentioned above, despite all of them reiterating how important sexuality is, they highlight that often no form of sexuality is addressed in training. When it is, the attempts are characterised as reductionist, negative, fragmented and lacking consistency. It is worth noting that the only studies to focus solely on CoP are by Abbott et al. (2021, 2022) and Mollen et al. (2020, 2022) and relate to North American trainees. Canvin et

al. (2023) constructionist narrative analysis refers to British mental health professionals and does not mention CoPs amongst participants. Giami's and Pacey's (2006) article survey European (UK included) health professionals that work in sexology, and it is unclear if and how many if any CoP. The survey by Shaw et al. (2008) focused on British clinical psychology training provision of sexuality. Perhaps this can partially be explained by CoP's identity development as seen below.

The profession of CoP began in the USA in the late 1940s but was not established in the UK until 1994. Since its inception, it has been particularly occupied with its own identity as well as similarities, and differences with other professions, namely Clinical Psychology (Orlans & Van Scoyoc, 2009; Strawbridge et al., 2016). It has been extremely important in the development of a CoP identity, the bringing together of "...the existential, humanistic, and phenomenological traditions, alongside psychodynamic, cognitive behavioural, social constructionist, narrative and systemic approaches" (Clark & Loeventhal in Richards & Barker, 2015, p. 281).

CoP adopts a pluralistic approach, which according to Cooper and McLeod (2011), implies that one question can have multiple valid responses. This points to "a preference for diversity over uniformity, multiplicity over unicity (McLellan, 1995), and pragmatism over idealism (James, 1996)" (p.27). This perspective is most suitable when addressing complex phenomena, such as sexuality, which involves working with multiple disciplines, interests, and practices (Manafi in Milton 2010). According to Neves and Davies (2023), the term GSRD captures that diversity of perspectives and experiences aligning itself with pluralism however, it is unknown if it is being used in CoP training and practice.

Humanism closely connects to pluralism. Although humanism has taken slightly different directions in Europe and the United States, they share some basic principles about human experience: being part of a uniquely human context; awareness of oneself with others;

having choices and responsibilities; and seeking meaning, value, and creativity (Orlans & Van Scoyoc, 2009). Humanism, described in this way, serves as an umbrella for existentialism and phenomenology. Phenomenology, as suggested by Husserl (1859-1938), is the study of objects and events as phenomena that present themselves to human consciousness (Strawbridge et al., 2016). Therefore, psychological research is subjective and aims to clarify people's experiences in everyday life. This is quite different from the positivist approach, which states that human experience can be understood objectively and reduced to variables that can be studied in a laboratory (Smith, 2003). As CoP promotes a subjective view of the world, it privileges qualitative methodology over quantitative. Nonetheless, in terms of sexuality, there are many quantitative studies, including randomised control trials (RCTs), but far fewer qualitative studies, even within the CoP (Hargons et al., 2017). One hypothesis might be the understanding of sexuality as a natural phenomenon, and research led by medical sciences (and clinical psychology), which tend to adopt a positivist stance (Hargons et al., 2017). This has been changing in recent years, with a greater focus on qualitative methodologies and intervention studies aimed at raising awareness of LGBTIQ issues; however, S. J. Ellis et al. (2019) also warn about the perpetuation of heteronormative cisgender and monogamic assumptions in research, making suggestions for 'good' LGBTIQ research practices. As Hargons et al. (2017) highlight, for other areas of sexuality, such as identity, pleasure, and general wellbeing, studies within a CoP framework are sparse. Despite the survey's focus on North America, its findings could potentially apply to the UK, where there is a dearth of research on sexuality and CoP.

Existentialism, another of CoP values, was developed by Heidegger (1813-1855) with a focus on "being in the world" (Heidegger, 1962 in Orlans & Van Scoyoc, 2009). In existentialism, "the emphasis (is) not on illness as per the medical model, nor on theoretically derived concepts of intrapsychic life, but on people's existence in the world and their aspirations for belonging, contact and health" (p. 50). As mentioned, the literature suggests that the work

on sexuality has traditionally deviated from this epistemological and ontological principle, although feminist and queer theories have been making a difference (S. J. Ellis et al., 2019). Authors, such as Martin Milton, have also highlighted the connection between sexuality, CoP and existential thinking (see Milton, 2014b), yet it remains unclear if and how this is reaching clinical practice.

Humanist principles underpin social justice. The core value of social justice presupposes that we exist in relation to and are situated within a wider context (Strawbridge et al., 2016). Applied to research and therapeutic practice, advocating for social justice involves reflecting on one's own position, requiring engagement with the power relations and ideological assumptions within the discipline and the wider society (Richards & Barker, 2015; Strawbridge et al., 2016). Some will argue (Manafi in Milton, 2010) that CoP has played a leading role in challenging a dualistic and realist view of the world by providing studies on cross-cultural, gender and LGBTIQ research. However, as Hargons et al. (2017) found, research on sexuality within CoP (in the USA) is often focused on issues of illness and dysfunction, possibly perpetuating sex-negative and discriminatory ideas. It is commonly accepted that social justice is an essential part of CoP's identity; however, a search of CoP handbooks rarely shows sexuality and social justice in the same chapters and lines of thinking (Arnold & Brewster, 2017; Galbraith, 2018; Orlans & Van Scoyoc, 2009; Strawbridge et al., 2016). There has been important output on affirmative practice when working with LGBTIQ and GSRD, with values of pluralism, humanism and social justice interwoven into. These are often linked with psychotherapy and psychology (M. L. Ellis, 1997; Hanley & Winter, 2023; Neves et al., 2023a; Neves & Davies, 2023) buy not particularly with CoP which might invalidate CoP obsession with its own identity.

Work towards social justice is ongoing for psychological therapists, although challenged by the fact that sexual norms and practices vary enormously across the world

(Popovic, 2006). Hicks (2010) argues that being part of an ethnic minority and having non-normative sexuality can pose specific challenges. Greene and Croom (1999) mentioned that it is not uncommon for LGBT (as used by the author) people to struggle to reconcile the different aspects of their identity, feeling that they must choose between their sexual identity and their ethnic one. The religions of clients and psychotherapists also affect how sexuality has been approached in research and therapy (see Hicks, 2010). It is worth remembering that before it was replaced by politics and science, it was organised religion that sanctioned sexual identity and behaviours (DeLamater & Plante, 2015; Green, 2006). Sexuality is absent from studies on ethnicity and mental health, while ethnicity is not featured on studies about gender and mental health (Richards & Barker, 2015). The lack of research into the intersectionality of sexuality, gender, ethnicity, culture, and religion has been addressed by CoP, however only tentatively (Das Nair & Butler, 2012). In practice, it is unclear how psychotherapists navigate and make sense of this diversity and how CoP's values might translate into practice.

When CoP was becoming established in the UK, the emphasis was on helping "the 'worried well' rather than the 'mentally ill'" (Orlans & Van Scoyoc, 2009, p.2), values that do not seem to apply to sexuality. This may be explained by the need for CoPs to use the medical model in practice (Verling, 2014). However, as Hicks (in Milton, 2010) stresses: "Counselling Psychology practice does not limit itself to the diagnostic and treatment model that seems to dominate much therapeutic discourse and health provision" (p. 254). He goes on further to highlight the role CoPs play in developing research that addresses set views of sexuality and pushes the debate and knowledge further. Nevertheless, as mentioned above, sexuality tends to be avoided or addressed from the standpoint of loss, trauma, or dysfunction. The systematic review by Hargons et al. (2017) in the USA found that 38% of the studies focused on sexual orientation, identity, and minorities, 24% on sexual abuse, objectification, or victimisation, and 15% on sexually transmitted infections and sexual risk. Although no equivalent review for the

UK has been found, there is reason to believe that the situation is similar. As research practitioners, where does the lack of research into sex-positivity and affirmative practice leave therapists, especially counselling psychologists?

This identified need was a catalyst for the development of this research project, namely the lack of research on how CoP and other psychological therapists are making sense of the available theory and currently addressing sexuality.

1.8 - Sexuality and therapy

Mcleod (2019) suggested that the roles of gender and sexuality in therapy theory, research, and practice are strikingly insignificant, despite its importance in people's lives. He states that "it is safe to assume that the majority of clients go through therapy without talking about their gender identity or sexuality at all" (p.377).

Therapy is diverse and can be related to many disciplines, but in this context, it stands for talking therapy or psychological treatment. According to the UKCP website, therapies "are used to treat emotional problems and mental health issues. As well as talking, the therapy could use a range of methods including art, music, drama, and movement" (*UKCP | About Psychotherapy*, n.d.). In this literature review, the terms psychology, counselling, psychotherapy, and therapy were used interchangeably, despite possible differences between practices, theories, and professional identity, as suggested in the specific section on CoP. The term therapist refers to clinical, counselling, forensic psychologists, counsellors, and psychotherapists. In the UK, therapists work in varied settings, such as private practices, education, charitable organisations, and the National Health Service. Therapists work in primary, secondary, and specialist care using dozens of models of therapy that span from just a few sessions to long-term therapy. They work with individuals, families, groups, teams, and

organisations (Verling, 2014). It is assumed that that diversity is reflected in how sexuality is addressed in therapy; however, there is limited research suggesting that this is the case.

Rizq (2013) suggested that the language we use dictates how we work with clients. For example, working in a service like IAPT (Increasing Access to Psychological Therapies (IAPT) renamed NHS Talking Therapies, focusing on evidence-based and outcome-focused interventions, will likely provide a different experience of therapy than working in private practice. Reviewing the literature by using the search terms "IAPT" and "sexuality" or "sex", only a few studies were found, focusing on treatment outcomes for LGBQ clients (Greene & Croom, 1999; Hambrook et al., 2022; Rimes et al., 2018). Given the number of therapists and clients in this service, there is a striking lack of research and literature on sexuality in primary psychological care. This finding is more significant given the well-established link between common mental health problems (treated in IAPT) and sexuality (Ali & Satinder, 2023; Blount et al., 2017; Dyer & Das Nair, 2013; S. A. Miller & Byers, 2011; Weeks, 2017).

Regardless of different contexts of practice, most studies suggest that talking about sex and sexuality is challenging and that addressing it might be left for specialist services, such as sexual health clinics, sexual trauma, and LGBT+ services (Burnes et al., 2017b; Butler et al., 2009; Cruz et al., 2017; Mosher, 2017; Shalev & Yerushalmi, 2009). However, is approaching sexuality in a "specialist service" any less challenging for psychotherapists? What makes them better prepared?

In a wider social framework, therapy is meant to be a safe environment in which all aspects of human experience are discussed in a non-judgemental manner (Cooper & McLeod, 2011). Sexuality appears to be an exception. For example, Benson (2013) and Bettergarcia and Israel (2018) studied the perspectives of transgender clients using therapy and found that therapists often rely on their clients to explain the nuances of gender and sexual orientation; clients and therapists express concerns about the lack of therapist education/training; therapists'

awareness of transgender issues has a positive impact on the therapeutic relationship. Both studies point out that "without research, training, and guidance regarding the complexity of experiences transgender people have in therapy, therapists are left with their assumptions, biases, stereotypes, and best guesses about how to work effectively with transgender clients" (Benson, 2013, p.424). The author reflects on how, with transgender clients, therapists should be aware that sometimes clients want to address issues other than their gender. Other authors point to analogous situations with other GSRD (e.g. Cross et al., 2023; Dispenza et al., 2017; Hambrook et al., 2022; Rimes et al., 2018). Dominic Davies and Silva Neves authored and edited several books and articles highlighting that despite therapists' best intentions, often the lack of training and learning opportunities let them and their clients down. They advocate for a change in vocabulary, such as referring to *relationship therapy* rather than couples therapy and point out to the singular (often alienating) experiences of Queer people living in a "heteronormative, mononormative, sex-negative and cisgenderist world" (p.2), setting out good practice guidelines and clinical examples of how to work with GRS diverse clients. Are these inclusive, innovative and affirmative ways of working reaching practitioners in the UK and how?

Markovic (2007) found that for systemic psychotherapists, talking about sex was experienced as "provocative" due to personal vulnerabilities triggered by the topic. The same study found that judgements, prejudices, inhibitions, and anxieties about sexuality are commonly activated in therapists. This seems to be especially true with forms of sexuality that are not heteronormative (Richards & Barker, 2015). One can assume that if these are common experiences for therapists, they are unlikely to proactively address sexuality.

Therefore, a lack of training, personal experiences, and assumptions are the most prominent reasons for not addressing sexuality (Burnes et al., 2017a). In recent surveys, trainees reported some coverage of sex and sexuality in clinical psychology courses, however

short, inconsistent, and not always applicable in clinical practice (Cosway & Rosan, 2018; Montenegro, 2015). Are these gaps in initial training mitigated by professional development opportunities, as suggested by the BPS guidelines (*Guidelines for Psychologists Working with Gender, Sexuality and Relationship Diversity*, 2019) in good practice?

The situation seems identical in other helping professions. Higgins et al. (2008) developed a grounded theory of mental health nurses' responses to sexual issues. They concluded that their main concerns "were related to feelings of personal and professional vulnerability, due to a lack of competence, comfort and confidence in this area" (p.1). These findings are consistent with Macleod and Nhamo-Murire's (2016) systematic review of nursing practices. The situation is similar in social work, where sexuality is generally addressed from a negative standpoint, with a focus on sexual abuse, violence, and disease (see Dodd & Tolman, 2017). There is a tendency to leave sexuality out of these helping relationships, which may perpetuate negative and discriminatory discourses, despite the many guidelines available (D. M.-J. Barker, 2017; Blount et al., 2017; Dodd & Tolman, 2017; Higgins et al., 2008; Shaw et al., 2012). Are these guidelines keeping up with the experiences on the ground, and are they filtering down into practice?

The decision to include or exclude sexual content from therapy may be linked to the therapeutic paradigm. As noted, psychoanalysis introduced the concept of psychosexual development; however, as found by Shalev and Yerushalmi (2009), therapists working psychodynamically tend to reframe or avoid the topic of sexuality in sessions altogether. In their grounded theory study, they interviewed ten psychologist and psychiatrists working psychoanalytically and found that the "majority of therapists interviewed did not regard sexuality as an organiser of psychic structure or as a factor that determines behaviour but as one of many manifestations of deeper psychic patterns"; therapists adopting a more supportive stance considered sexuality as theme for an "advanced stage of therapy" that is often not

reached; a “narrowing of the concept of sexuality” usually to mean only sexual encounters and a “separation between intimacy and sexuality”; therapists tend to avoid “sexual issues because of the discomfort they cause”. Mary Target (2007) and Peter Fonagy (2008) suggest that the psychoanalytic focus on transference, attachment and interpersonal subjectivity is at odds with the conflict and emotional arousal inherent to psychosexuality and with the acceptance of infantile sexuality. In Fonagy’s 2008’s article “A Genuinely Developmental Theory of Sexual Enjoyment and Its Implications for Psychoanalytic Technique”, he points to a survey conducted by the author that show a decline in the use of words relating to sexuality in psychoanalytic articles which they correlate to an increase in “relational theoretical words”. In 2009, the author puts forward several hypotheses for why sexuality seems absent from psychoanalytic work, further corroborating Shalev's and Yerushalmi's (2009) grounded theory.

Daines and Perret's (2000) recent attempt to apply psychodynamic thinking to sexual problems, while welcoming, is still primarily concerned with illness and dysfunction in sex therapy. What about sexual health and wellbeing?

Most studies have found that the treatment of sexual dysfunction uses cognitive behavioural therapy (CBT) or some kind of behavioural approach based on Masters and Johnson’s work (Berry & Lezos, 2017; Pukall, 2009)A review of the literature suggests that sexual dysfunction is mainly a female problem and that CBT (in some form) is an evidence-based treatment (Brotto et al., 2017; Meyers et al., 2022). Other authors have discussed mindfulness as a treatment for sexual dissatisfaction for both individuals and couples (e.g. (McCarthy & Wald, 2013; Stephenson & Kerth, 2017).

CBT is also the preferred therapy for people with acquired physical disabilities (Kedde et al., 2010; Tellier & Calleja, 2017). Another aspect of working with disability is the notion of consent, the lack of clear guidance on what it entails, and how to promote sexual wellbeing

and inclusion among disabled clients (Denman, 2003). Is this intersection and others on therapist's awareness?

Some have reported that person-centred psychotherapy is the most effective for clients who experience trauma resulting from sexual assault, as well as for clients with disabilities (see (Scholl et al., 2014; Tellier & Calleja, 2017). A humanist approach can help clients focus on creativity and growth in their sexual development, and it can help therapists view clients holistically with unconditional positive regard that reinforces human sexuality as normal and healthy (Tiefer, 2006 in Tellier & Calleja, 2017). Are existential principles used in practice?

For other mental health presentations such as complex trauma and PTSD, research acknowledges the usefulness of other therapeutic models such as eye movement desensitisation and reprocessing (EMDR), biofeedback, dialectical behavioural therapy (DBT), relational psychoanalysis, and CBT (see Athanasiadou-Lewis, 2017; Nair & Shukla, 2017). However, this list is incomplete, and there are debates on what model of therapy provides the best outcomes and why. Given the prevalence of sexual trauma and the likelihood that psychotherapist's have, at some point, worked with survivors (Athanasiadou-Lewis, 2017; Elkjaer et al., 2014; Harrison, 2001; Nair & Shukla, 2017; Peskin et al., 2018), what are therapists' favoured models and approaches?

As indicated in this section and above, the model of therapy employed will likely impact how therapists conceptualise sexuality. For example, the psychodynamic model

> employs major concepts of psychoanalytic theory to understand clients, including the enduring importance and impact of psychosexual, psychosocial, and object relational stages of development; the existence of unconscious cognitive, emotional, and motivational processes; and the re-enactment in the client's relationship with the therapist and others of emotion-laden issues from the past (Messer, 2001, p.6).

Unfortunately, it is still unclear what role sexuality has in client difficulties and how comfortable psychodynamic therapists are to discuss them (Shalev & Yerushalmi, 2009). This seems to be the case despite important contemporary theoretical works by psychoanalysts like Galit Atlas (Atlas, 2013, 2015, 2018; Benjamin & Atlas, 2015), Avgi Saketopoulou (Saketopoulou, 2023; Saketopoulou & Pellegrini, 2023), Alessandra Lemma and Paul Lynch (Lemma & Lynch, 2015) and Peter Fonagy (Fonagy, 2008) amongst others. Atlas (2018) makes an interesting critique of the state of psychoanalysis when it comes to sexuality, pointing to a binary focus on what is observable (Pragmatic) and what is inferred (Enigmatic), highlighting the split between contemporary (relational) and traditional psychoanalysis. By following the traditional psychoanalytic case study method, her work remains 'opaque' to most psychotherapists. It is also worth mentioning that these conceptual developments might not easily be generalised to non-psychoanalytic psychotherapists working with populations from different (lower) classes and socio-economic status.

The image becomes murkier when we look at other models of therapy, such as CBT, where the conceptualisation of sexuality seems firmly rooted in the biomedical paradigm (Athanasiadou-Lewis, 2017; Richards & Barker, 2015; Štulhofer, 2015). In these models, references to sexuality seem to only be within sex therapy and are highly associated with treating dysfunction. Some authors argue that models such ad CBT, have been rendering different experiences of gender and sexual orientation invisible, because one relies on mechanistic and 'universal' models of the mind (Milton, 2014b).

In family and couples' therapy, where sexuality is expected to play a substantial role, several studies suggest that therapists find discussing sexuality challenging, and when they do, it is often from a sex-negative perspective (Barnes, 1995; Chui et al., 2018; Harris & Hays, 2008; Zamboni, 2015; Zamboni & Zaid, 2017). The authors suggest that discomfort can be

mitigated by extensive training in all aspects of sexuality and good person-centred supervision; the same authors highlight that these resources might are not as accessible as one would hope.

Studies on therapist effectiveness often place importance on aspects such as neutrality, non-self-disclosure, being a blank screen and, bracketing own material but clients still infer therapists' sexuality which influences therapy outcomes (Milton, 2017; Ryden & Loewenthal, 2001). Some studies of LGBTIQ clients suggest better treatment outcomes when they know that the therapist also belongs to a sexual minority. Therefore, it is generally agreed that the gender and sexual orientations of the client and the therapist have implications for the therapeutic relationship (Beel et al., 2018; Berry & Lezos, 2017; Bettergarcia & Israel, 2018; Dispenza et al., 2017; Gehart & Lyle, 2001; Gilbert & Leahy, 2009; Ritter & Terndrup, 2002; Ryden & Loewenthal, 2001). The authors suggest actions that can be taken to mitigate or improve their impact on the therapeutic process, but most of these studies focus on the experiences and expectations of clients, leaving a gap when it comes to therapists. Most authors stress the importance of the therapeutic relationship over the therapeutic model, suggesting that therapists' feelings of shame, guilt, embarrassment, and discomfort have a negative impact but could be mitigated by a strong working alliance (Butler et al., 2009; Gehart & Lyle, 2001; Gelso et al., 2014; Gilbert & Leahy, 2009; R. Knox & Cooper, 2014). These are mostly theoretical ideas that might not be reflected in therapists' experiences. Furthermore, a study on consensual non-monogamous client's perceptions of therapy (Rossman et al., 2019) found that the degree of safety and trust clients have in their therapist (or mental health practitioner) is strengthened by the therapist's affirmative stance and thus has a positive impact on therapy outcomes. Another study suggested that a weak therapeutic alliance is more likely to lead to premature termination of therapy, which has been found to dramatically reduce the efficacy of therapeutic interventions (Heilbrun, 1982; Pekarik, 1992 in Schechinger et al., 2018). It makes

sense to assume that sexuality will be addressed if there is a strong therapeutic relationship; however, that might not feel relevant to therapists.

The discrepancy between the gender of the client and the therapist and sexual orientation, as well as its impact on the therapeutic relationship and outcome, could also be mitigated by therapists' knowledge about sexuality. This goes back to the need for thorough and comprehensive sexuality training, which many other authors suggest is lacking in graduate and post-graduate training courses across psychological modalities and countries (Abbott et al., 2021, 2022; Burnes et al., 2017b; Chui et al., 2018; Cosway & Rosan, 2018; Cruz et al., 2017; S. A. Miller & Byers, 2011; Mollen et al., 2020; Mollen & Abbott, 2022; Zamboni & Zaid, 2017).

Lastly, regarding sexuality and therapy, there is the issue of sexual attraction between the therapist and client. Despite the existence of guidelines dating back to ancient Greeks advising against sexual involvement between professionals and patients, the plethora of anecdotal cases and lawsuits in the USA indicate that sexual involvement is still prevalent (Ben-Ari & Somer, 2004; Gelso et al., 2014; Pope et al., 2006; Somer & Nachmani, 2005). Even in the absence of physical involvement, the literature suggests that sexual or romantic attraction between the therapist and client is an important phenomenon to consider. Regardless of the therapy model, this relationship is actively discouraged in training and ethical guidelines. Recognising that this still happens, how are psychotherapists dealing with their clients' sexual or romantic feelings and their own?

This review was focused on general practitioners rather than sex therapists because of the possibly erroneous assumption that the latter would necessarily feel comfortable and willing to address sexuality and would have the adequate training to do so. There is debate about what makes sex therapy different from other therapies, what areas it should address and what models are better to do so (Athanasiadou-Lewis, 2017; Barnes, 1995; Daines & Perret,

2000; Peterson, 2017; Pukall, 2009). There is also debate about what is the best terminology: 'sex therapy' or 'psychosexual therapy' and what training and certification processes are or should be in place (see Nasserzadeh, 2009). In the UK, there's been some interesting developments around sex therapy and GSRD in the last 40 years with for example the development of the College of Sexual and Relationship Therapists (CORST) and the development of Pink Therapy directory and related publications (e.g. Neves, 2023; Neves et al., 2023b, 2023a; Neves & Davies, 2023) however, as Silva Neves (2023) questions therapists: "Are you GSRD competent?"

As discussed above, there is a strong association between common mental health presentations and sexuality (Blount et al., 2017; Butler et al., 2009; Cruz et al., 2017; Denman, 2003; Dyer & Das Nair, 2013; Weeks, 2017), therefore the aim of this study was to understand how 'general' psychological therapists address sexuality in non-specialist therapy.

1.9 – Summary of the literature review

Based on this critical review of the literature, sexuality remains a highly debated topic within sociological, biological, and psychological fields (Denman, 2003; S. J. Ellis et al., 2019; Weeks, 2017). It remains unclear what conceptualisations of sexuality are more prevalent and useful to psychological therapists in practice. This is important because of the amount of guidelines and recommendations for good practice, especially targeted at therapists working with LGBTIQ and GSRD (D. M.-J. Barker, 2017; Butler et al., 2009; Daines & Perret, 2000; Lemma & Lynch, 2015; Milton, 2014a; Neal & Davies, 2000; Ritter & Terndrup, 2002; Shaw et al., 2012). These guidelines, notwithstanding their helpfulness and usefulness, are mostly based on theoretical underpinnings and client's experiences. This points to a gap in the literature about the experiences of psychological therapists working in general settings addressing sexuality. Therefore, the aim of this research is to develop a grounded theory of

how therapists address sexuality in therapy and answer some of the questions elicited during the literature review.

Chapter 2. Methodology

2.1 - Overview

This chapter provides a rationale for choosing a qualitative approach and constructivist Grounded Theory in particular. The process involved in the choice, including ontological and epistemological considerations, is outlined. Grounded Theory is presented as the chosen methodology with a particular focus on its history and researcher identification with the constructivist version of Charmaz (2014).

Next, the research procedures are described, including data collection, analysis, and a description of how the model was constructed. After ethical, validity and reliability considerations, the model is presented pictorially and narratively, firstly in the words of participants and then framed theoretically.

The section ends with the researcher's reflection on the methodological process.

2.2 - Ontology and epistemology

To explain the choice of methodology, it is necessary to have a wider understanding of the CoP's values and how they relate to the two philosophical concepts above: what we can know (ontology) and how we can know it (epistemology).

Orlans and Van Scoyoc (2009) argue that, philosophically, CoP "focuses on humanistic ideas of a holistic kind" (p.22). They also defend that pluralism is at the very core of CoP, meaning that counselling psychologists tend to identify with the idea that multiple realities exist and there are different ways of 'knowing' them, which incentivises methodological pluralism (Kasket, 2013; Willig, 2022).

When developing the research question, the researcher considered the tension between humanist and positivist values that permeate CoPs' clinical practice, training, and research (Orlans & Van Scoyoc, 2009). However, the researcher was more aligned with ideas about pragmatism, social constructionism, and subjectivity, thereby identifying more closely with qualitative research methods (Kasket, 2013; Murphy, 2017; Orlans & Van Scoyoc, 2009; Strawbridge et al., 2016). As the authors further stress, among the psychological disciplines, CoP stands out for its emphasis on diversity, inclusion of context, and well-being rather than illness. In qualitative research, it is accepted and welcomed that researchers will influence the research process (Smith, 2003; Willig, 2012, 2022) which seems to align well with the onus that CoPs puts on subjectivity and reflexivity (Orlans & Van Scoyoc, 2009; Strawbridge et al., 2016).

Although the alignment with qualitative methodology was more of a natural fit, the choice of methodology was a process of enquiry in which quantitative research was considered. Quantitative research relies on ideas such as empiricism (the only reliable knowledge is that derived from direct observation), quantification (reality can be represented in numbers), universalism (knowledge is fixed and does not vary across time, space, and context), and naturalism (everything is governed and determined by natural laws) (Slife & Gantt, 1999 in Kasket, 2013). As Willig (2022) succinctly puts it: "positivists believe that it is possible to describe what is 'out there' and to get it right" (p.2). On the other side of the ontological and epistemological realism lies relativism which tends to reject concepts as "truth" or "knowledge" which ultimately make it impossible to know anything. As discussed below, the method chosen, Constructivist Grounded Theory (CGT), has been seen as an attempt to bridge realism and relativism (Willig, 2022), although there is still much debate about its ontological and epistemological positioning.

In contrast to quantitative methods, which focus on numerical data and analysis, qualitative methods typically involve examining, describing, and interpreting the personal and social experiences of participants using language and symbolism as primary tools (Smith, 2003; Willig, 2012, 2022). Historically, qualitative methods have served as a cornerstone for advancing theory and practice in counselling and psychotherapy. The origins of qualitative research in psychotherapy coincide with the development of the field. In the late 1800s, Sigmund Freud (1925) developed the 'talking cure', which, by focusing on understanding clients' experiences of certain phenomena, was, in some ways, the precursor of qualitative research in psychology (Ponterotto et al., 2017). Although quantitative methods and a positivist approach prevail in psychology (i.e. value given to randomised controlled trials), changes have been seen in the last two decades when more flexible and humanist methods are used (see (Willig & Rogers, 2017) .

As Ponterotto et al. (2017) point out, qualitative methodologies, especially CGT, are most useful in the exploratory phase in the absence of a prior theory related to the phenomenon. Sexuality research is scarce from a CoP perspective in contrast to other disciplines like medicine, biomedical, and social sciences (Hargons et al., 2017). As the authors found, drawing from the natural sciences, publications on sexuality and CoP tend to use quantitative methodology, mainly focusing on trauma, STIs, sexual dysfunction, and gender issues. "Topics around gay, lesbian, bisexual and transgender issues and counselling approaches is the fourth most researched topic in counselling psychology" (Ponterotto et al., 2017, p.503) but most from a perspective of illness and problem. As it became evident during the literature review, research focusing on psychology and sexuality from the therapist's perspective is even scarcer. Within psychology, socially constructed theories of sexuality are increasingly prevalent, but the methods of research are still overwhelmingly positioned in positivist and essentialist roots (see (S. J. Ellis et al., 2019; Hargons et al., 2017). This highlights how "psychology has continued

its extensive empirical productivity – measured in numbers of publications – without a breakthrough in theory" (Valsiner & van der Veer in Yasnitsky et al., 2014, p.149).

Therefore, social constructivism seemed the most appropriate methodology for understanding the processes involved in addressing sexuality in therapy. Social constructionism and constructivism paradigms were partly developed as a reaction to the positivist movement that enveloped the scientific world in the late nineteenth and early twentieth centuries (Hargons et al., 2017). Social constructionism is a post-modern philosophical movement according to which there is no unitary way of perceiving reality because multiple constructed realities may coexist (Burr, 2015; Gergen, 2022; McNamee et al., 2020). It places great emphasis on the language and meaning that give rise to multiple realities (C. Barker et al., 2015) and views meaning-making as a relational activity (ibid). Succinctly, "social constructionism draws attention to the fact that human experience, including perception, is mediated historically, culturally and linguistically" (Willig, 2022, p.15). This framework is particularly relevant for addressing sexuality, as it challenges essentialist and naturalist views and emphasises agency and empowerment for individuals who may have been overlooked (S. J. Ellis et al., 2019) which can include therapists addressing sexuality.

Social constructionism informs other methods of research besides CGT; therefore, more thought is now given to other methods of research.

2.3 – Rationale for using Constructivist Grounded Theory

The researcher's identification with social constructionist and symbolic interactionist and cultural historical stances (Burr, 2015; Charmaz, 2014; Gergen, 2022; Holzman, 2016; Robbins & Stetsenko, 2002) shaped the choice of topic, literature review, and methodology. Charmaz developed CGT as an alternative to the initial modernist, critical realist versions of

grounded theory, addressing the lack of acknowledgement of the researcher's involvement in constructing knowledge (Bryant & Charmaz, 2019; Charmaz, 2014; Charmaz & Henwood, 2017).

CGT allows the researcher to address emerging themes throughout the research process by analysing and co-constructing the intrapersonal, interpersonal, and social processes involved (Charmaz, 2014). These foci and theory development are the main reasons for choosing CGT over other qualitative methods such as Interpretative Phenomenological Analysis (IPA) and Discourse Analysis (DA), although these are popular qualitative methods in sexuality research, especially regarding gender and sexual orientation.

DA is another qualitative method that closely aligns with social constructionism; however, the research questions and aims differ from those of CGT (Burr, 2015; Gergen, 2022; Willig, 2022; Willig & Rogers, 2017). There are at least two different forms of DA, but succinctly all aim to understand how language shapes social narratives, looking at how discourses are socially constructed (Willig in Smith, 2003).

The focus on discursive construction neglects the subjectivity and agency of participants and researchers in the construction and use of those discourses, leaving out the question of why people use certain discourse resources in certain ways and contexts (Starks & Brown Trinidad, 2007; Willig, 2022). As much as this study looks at social narratives around sexuality and therapy and how therapists make use of language and symbols, the main goal is to learn therapists' interpersonal and intrapersonal processes, where language is one factor. DA falls short of achieving this goal. Another reason to choose CGT over DA is the aim to derive a theory from the data that can help explain the processes at play and be used to inform clinical practice, one of the core values for research in CoP (Davey, 2013).

Similarly, CGT, DA, and IPA place importance on the use of language. While DA focuses on the context of language, IPA aims to explore the individual and experiential

frameworks that lie beneath the language used (Brough, 2019). CGT builds on these methods and examines internal experiences, social construction of language, and the interplay between these two processes.

IPA is a phenomenological approach that focuses on individual experiences of something. It is based on the European philosophy of the 20th century, namely Husserl, who posits that we can only know the world as it presents itself to human beings in a specific context (Willig, 2022). As a method, it focuses on how participants make sense of their personal and social world, avoiding generalisations (Smith & Osborne in Smith, 2003). This is at odds with the researcher's aim to develop a theory that helps explain these phenomena. There are two forms of IPA: descriptive and interpretative. The descriptive form seeks to accurately describe a psychological phenomenon as experienced by the participant. To achieve this, the researcher must 'bracket their assumptions' (Willig, 2022). The interpretative form relies on double hermeneutics which means that "the participants are trying to make sense of their world; the researcher is trying to make sense of their participants trying to make sense of their world" (Smith & Osborne in Smith, 2003, p.51).

Phenomenological methods are well suited for uncovering the meaning of a client's 'lived' experience in relation to their "individual relationship with time, space, and personal history" (Goulding, 2005, p. 303) within the interpersonal and socio-cultural context (Smith, 2003). For the researcher, the question arises as to how the insights gained from this method can be used to meaningfully inform clinical practice. Meanwhile, the goal of CGT is to develop "grounded theory studies that inform policy and practice" (Charmaz in Morse et al., 2021, p.156).

As indicated above, the main objective of this research was to understand the current practices and processes involved in addressing sexuality in therapy which fits well with CGT, as described by Charmaz (2014). In this version of Grounded Theory (GT), it is assumed that

multiple realities exist; data reflect researchers' and research participants' mutual constructions, and the researcher incompletely enters the participants' world and is affected by it (Charmaz in Smith, 2003) It is important to notice that CGT differs in many ways from the earlier versions of GT, not just in terms of method but also in terms of epistemology, moving from critical realism and objectivism towards social constructionism and pragmatism (Bryant & Charmaz, 2019; Charmaz, 2014; Charmaz & Henwood, 2017; Morse et al., 2021; Smith, 2003; Willig, 2022). Contrary to other qualitative methods that focus on thematic syntheses rather than integrated conceptual analyses that are theoretically grounded, CGT focuses on the latter (Charmaz in Morse et all, 2021).

Grounded theory was born from the joint work of Anselm Strauss and Barney Glaser in the 1960s:

> Glaser drew on his rigorous training in quantitative methods and imported positivist assumptions of objectivity, parsimony, and generality into grounded theory. Strauss brought the pragmatist emphases on agency, action, language and meaning, and emergence to grounded theory, all of which support its constructivist leanings. (Charmaz & Henwood, 2017, p. 242)

Soon after the development of the methodology, the authors went in separate ways, creating two different approaches to grounded theory. Glaser's GT adheres to positivist principles of discovery, objectivity, and generalisation (Charmaz & Henwood, 2017; Morse et al., 2021), putting his approach at odds with the researcher's identification with subjectivity and social constructionism. Strauss in his work with Juliet Corbin added technical procedures and offered clear and specific analytic strategies of data, such as axial coding but Charmaz argues that it remains a modernist approach in that it does not account for the research itself as constructed (Bryant & Charmaz, 2019; Charmaz, 2014; Charmaz & Henwood, 2017; Morse et al., 2021). Although not explored further due to space limitations, other forms of qualitative

enquiry derived from grounded theory include dimensional and situational analyses, methods discussed in detail by Morse et al. (2021).

The constructivist approach emphasises reflexivity and considers the researcher's starting points, standpoints, and conditions before and during enquiry. Constructivists view data as contingent on language, co-constructed with participants, and rooted in relationships and social, cultural, historical, and situational conditions, bringing a pragmatist perspective to GT (Willig & Rogers, 2017).

2.4 - Participants and recruitment

There is a distinction between theoretical sampling and other types of sampling. Initial sampling is the starting point and "relies on establishing criteria and planning how you will access data" (Charmaz, 2014, p.197).

The participants of this study were psychological therapists working in the UK, specifically in Greater London. Initially, the recruitment criteria were restricted to counselling psychologists because literature suggests that their professional identity is different from that of other applied psychologists (Milton, 2010; Orlans & Van Scoyoc, 2009; Strawbridge et al., 2016) and because the study was conducted for the purposes of completing the CoP Professional Doctorate. Due to recruitment challenges and after consideration in supervision, the researcher opened the study to all psychological and talking therapists, which significantly enhanced the diversity and scope of this investigation. As shown in Table 1, participants included one CBT therapist, three clinical psychologists, one forensic and counselling psychologist, three counselling psychologists, and one systemic therapist.

Table.1

Pseudonym	Age	Gender	Sexual Orientation	Ethnicity	Professional title	Main model of therapy
Sam	ND*	Male	Heterosexual	White British	CoP/Forensic Psychologist	Psychodynamic
Nanda	30-39	Female	Heterosexual	Asian - Indian	Counselling Psychologist	Integrative/ psychodynamic
Carol	ND	Female	ND	ND	Counselling Psychologist	CBT
Heather	30-39	Female	Omnisexual	White British	Counselling Psychologist	Pluralistic
Lucy	30-39	Female	Heterosexual	White British	Clinical Psychologist	Eye Movement Desensitization and Reprocessing (EMDR)
Mike	30-39	Male	Heterosexual	Black British	CBT & EMDR therapist	CBT/EMDR
Summer	50-59	Female	Gay	White British	Systemic Family Therapist	Systemic Psychotherapy
Sabrina	30-39	Female	Heterosexual	White other	Clinical Psychologist	CBT (third wave)
Anna J	50-59	Female	Heterosexual	White British	Psychotherapist	Integrative
Alexandra	ND	Female	ND	White other	Clinical Psychologist	Integrative

Geographically, literature suggests that England and London are specific contexts with significant differences from other countries and areas of the UK (e.g. *People, Population and Community - Office for National Statistics*, n.d.). For example, London is a large urban centre with higher levels of ethnicity, religious, gender and sexual orientation diversity. It also has the highest concentration of NHS services in the country, being the biggest employer of therapists (see Hanley & Winter, 2023; Murphy, 2017; Strawbridge et al., 2016).

Although from different nationalities and backgrounds, all participants have mainly practised in Southeast England. As seen in Table 1 of the ten participants, five identify as White British, two as White Other (in this case European), one as Black British and one as Asian Indian.

From informal conversations with participants, there is some diversity with some alluding to recent qualification while others have been working for over twenty years. It is worth noting that routes to qualify as a psychological therapist in the UK are quite diverse and some of that diversity is captured in this sample, contributing to the reach of the resulting theory.

Given that most research has focused on sexual orientation, gender and identity, sexual trauma, and sexually transmitted illnesses (Hargons et al., 2017), the researcher sought therapists working in general settings, either in the NHS, the third sector, or privately. It was assumed that psychological therapists working in sexual health or gender identity clinics (GIC) would have a particular interest in sexuality, and addressing sexuality would be more likely and perhaps standardised. For saturation, invitations were sent to three psychosexual clinics and one GIC; however, no participants were recruited in this manner. Participant Alexandra worked in a sexual health clinic and brought her insights into the interview, contributing to theoretical saturation.

Following Willig's (2022) suggestions, participants were asked to use their own words to describe their gender and sexual orientation. Eight participants identified as female and two as male. Six participants identified as heterosexual, one as gay and one as omnisexual. Two participants did not disclose their sexual orientation.

The most important exclusion criterion was that therapists must actively be in clinical roles, excluding retired therapists, only offering supervision, and in managerial positions without client contact. The researcher was interested in the processes inherent to the clinical

work and how these are linked to sexuality; therefore, psychological therapists had to actively deliver therapy.

In CGT, there are no set guidelines for the number of participants (Charmaz, 2014); however, the initial goal was to recruit approximately twelve psychological therapists. Due to academic time constraints and recruitment difficulties discussed further in the reflective statement, ten participants were recruited and interviewed. Despite the intention to align with CGT guidelines and reach theoretical saturation (Charmaz, 2014), the goals were only partly achieved, not only because of number of participants but because of the potential diversity amongst therapists According to the author when collecting fresh data ceases to generate novel theoretical perspectives or expose unseen aspects of theoretical categories, the categories are considered saturated. The researcher discussed follow-up questions and further interviews with the participants to clarify emerging categories from their interviews and conducted informal conversations to achieve this. For example, the demographic information in Table 1 was requested months after the interviews and after it emerged in coding that sexual orientation, gender and model could be important in analysing the emerging data.

Recruitment was conducted through advertising and snowball. Previous and current supervisors and therapists were contacted directly via emails. Four participants were recruited through the Counselling Directory Notice Board, three through direct contact with advertising in the current place of work, and one through advertisement on Facebook's psychology groups. The researcher contacted the BPS and the BACP, and both agreed to advertise the research; however, this was never actioned, and no participants were recruited through these channels. The text in Appendix 1 was used for advertising, although this version was used after the change in the recruitment criteria. Participants were contacted by message, phone, and email, depending on the channel they first used to express their interest. This initial contact allowed the researcher to ensure that the participants met the inclusion criteria.

Table 1 provides the participants' pseudonyms, demographics and preferred model of therapy.

2.5 - Data collection

GT allows for different methods of data collection ranging from naturalistic observations to text analysis, interviews, and focus groups. Individual intensive interviews were chosen for several reasons, namely, difficulty in obtaining ethnographic data (Charmaz, 2014), possible parallels between interviews and one-to-one therapy processes, and researcher and participants' familiarity with interviews as data collection methods.

After the initial contact, participants were provided with full information about the study (see Appendix 2) and were asked to sign the consent form, as shown in Appendix 3.

Interviews were conducted using online platforms, specifically Zoom and MSTeams. The use of online platforms was partly a constraint caused by the pandemic and partly by choice due to the convenience of recording, less travel costs, time, and space required (Brown, 2022). In addition to audio and visual information (during the interviews), notes were also taken. Some of these notes later became memos and informed changes in the interview schedule. For example, trauma and dialects were mentioned in the first 3 interviews. Trauma became a line of enquiry in the new interview schedule seen in Appendix 5.

Regardless of the medium, the basic principle of qualitative research data-collection techniques is to be participant-led and bottom-up (Bryant & Charmaz, 2019; Charmaz, 2014; Charmaz & Henwood, 2017). To achieve this, the initial interview schedule was constituted of mainly open-ended questions (see Appendix 4) "flexible enough to facilitate the emergence of new, and unanticipated categories of meaning and experience" (Willig, 2022, p.29) and "following up on unanticipated areas of enquiry, hints and implicit views and accounts of actions" (Charmaz, 2014, p.56).

All interviews started with the main research question, which was open-ended, leading in different directions for each participant. The initial interview schedule was modified (Appendix 5) to reflect the emerging theoretical codes, and theoretical sampling was conducted after coding the initial five interviews. Theoretical sampling is a data collection strategy that focuses questions on emerging conceptual ideas rather than gathering extensive but irrelevant information (Bryant & Charmaz, 2019; Charmaz, 2014; Charmaz & Henwood, 2017; Morse et al., 2021). Nonetheless, this is a complex abductive process that was only partially followed in this research project, mainly because of time constraints. This study used theoretical sampling by incorporating enquiries about trauma in interviews and interviewing therapists specialising in trauma work when the researcher discovered that sexual trauma could be a gateway for discussing sexuality. Pursuing this line of enquiry led to the creation of the theoretical category: "negotiating permission". This process is further addressed in the data analysis section.

2.6 - Ethical considerations

This study was conducted in line with the ethical research guidelines of the BPS (Hewson & Buchanan, 2021; Oates et al., 2021) and the Health and Care Professions Council (HCPC, 2023).

Ethical approval was obtained from London Metropolitan University on March 23rd, 2021, and again informally in December, to reflect the changes to participant recruitment (Appendix 6). Although some of the participants worked for statutory services such as the National Health Service, they did not participate in their employee capacity; therefore, no ethical approval or permission from any other body was needed.

Given the specificities of sexuality, other ethical considerations were taken, namely that it was left to the participants to choose what language and labels to use when describing their gender, ethnicity and sexual orientation. That information was collected in a follow-up email,

and it was stressed that providing this information was optional. There was also consideration given to the interview schedule so that it did not include heterosexist, monogamic and cisgender assumptions and language. These considerations were based on reflections and suggestions for research by, for example by Das Nair ans Butler (2012) and S. J. Ellis et al. (2019).

2.6.1 - Informed consent

Participants provided written consent prior to the interview which was reviewed verbally at the start of each interview. The consent form (Appendix 3) and information sheet (Appendix 2) explain how the data were collected, stored, and treated. Issues of anonymisation, privacy and confidentiality were discussed, as was, in some cases, what identifiable information would be removed from the transcripts. Participants were informed that they had the right to withdraw consent and were provided with a timeframe to do so. Once the signed consent forms were returned via email, they were kept in a password-protected folder and reviewed by the participant during the introductory part of the interview.

2.6.2 - Confidentiality

Both the researcher and participants ensured sufficient privacy in their physical spaces. The platforms for the interviews (Zoom and MSTeams) and recordings (Dictaphone and online platform) were pre-agreed upon to ensure participants' confidence in the confidentiality and anonymity procedures. The audio recordings and transcripts were saved under initials and number codes, and all names and identifiable information were removed from the transcripts prior to the analysis. All data were stored on a password-protected laptop and used in password-protected software for transcription (i.e. Otter.ai.). During the transcription, all identifiable information was removed. The transcripts were then analysed in password-protected software (see data analysis for more on the software used). All procedures followed guidance from the

BPS (Hewson & Buchanan, 2021; Oates et al., 2021) and Data Protection (Data Protection Act 2018, n.d.).

2.6.3 - Distress

It was not anticipated that participants would experience undue distress arising from their participation, and there was no formal distress protocol. Signs of distress were monitored by the researcher during and after the interviews. Most participants shared personal experiences during the interview, and at the end, the researcher offered them the opportunity to discuss the experience further. Participants were invited to ask questions and discuss any resulting distress at the end of the interviews. They were also sent a debrief sheet (Appendix 7) and invited to contact the researcher in case of distress or any other untoward event.

2.7 - Data analysis

The interviews were recorded and fully transcribed using the Otter.ai software. All data were stored on a password-protected personal laptop in line with the BPS and Data Protection Guidelines (*Data Protection Act 2018*, n.d.; Hewson & Buchanan, 2021; Oates et al., 2021). The computer software Atlas.ti (Friese, 2012, 2016) was utilised throughout the research process to help manage, organise, and analyse the data. The researcher started with manual coding; however, the amount of data and the need to have all transcripts, memos, and codes stored in an organised and easy-to-access system led to considering computer-assisted tools. Having tried different Computer Assisted Qualitative Data analysis software (CAQDAS), Atlas.it seemed the most congruent with grounded theory (Willig, 2022), the most user-friendly, and financially viable. This was a personal choice based on the scant literature available at the time on the use of CAQDAS in qualitative research (Bryant & Charmaz, 2019; Friese, 2012, 2016; Silver & Lewins, 2014; Willig, 2022).

2.7.1 - Initial coding

In constructivist grounded theory, data analysis and gathering are concomitant and influence each other (Charmaz, 2014). The researcher worked on the initial coding during and after the data collection process. The analysis started line-by-line in a process of constant comparison with the initial data other codes, and newly gathered data (e.g. that derived from the ongoing interview process). As seen in Appendix 8, the initial codes used participants' own language and were related to the data as closely as possible. Following CGT closely, the initial codes remained open and close to the data, capturing subjective and objective actions (Bryant & Charmaz, 2019; Charmaz, 2014; Charmaz & Henwood, 2017; Charmaz & Thornberg, 2021). Because grounded theory "coding fosters studying action and processes" (Charmaz, 2014, p.113) these codes were formulated, when possible, using gerunds. Appendix 8 provides an excerpt of the initial line-by-line coding as completed in Atlas.ti. As research progressed, namely after the first four interviews, the researcher also used incident-by-incident coding, reflecting a move towards focused coding, where the codes identified initially were used to synthesise and explain larger segments of data, such as sentences (Charmaz, 2014). In the incident-by-incident coding some of the initial codes were used and new codes added and reformulated as seen in Appendix 8.

2.7.2 - Focused coding

Focused coding expedites the research process by using the most frequent and/or significant initial codes to study, sort, compare, and synthesise large amounts of data (Charmaz, 2014; Willig, 2022). The software's assistance in providing ongoing information on commonly used codes enabled a comparison of similar and contrasting codes across various instances. For example, it would show when a code had already been used, how many times,

and by which participant and allowed to include notes (memos) to clarify meanings (see Appendix 9)

After open coding the first four interviews, the researcher had approximately 700 initial codes. The most frequent codes were continuously selected, merged, and separated (see Appendix 9). Some codes were maintained for their importance and theory development potential; for example, one initial code around feeling discomfort was kept in one form or another throughout the analytical process. The process involved integrating new codes into pre-existing focused codes or constructing new focused codes through a process of permanent comparison, deconstruction, and construction. Codes were compared between interviews, within each interview, with memos and other codes (Charmaz, 2014; Willig, 2022), following Friese's (in Bryant & Charmaz, 2019) advice on the use of Atlas.ti. The idea of discomfort kept appearing in different forms from the initial coding to the final theory and in different interviews in different forms. Some therapists sometimes thought it was essential and helpful other times something to overcome. In different instances, it was associated with the client, the therapist and the researcher. Therefore, when focusing the code, the term was included and excluded, constructed and deconstructed several times until it became inconspicuous but transversal to the model. Other examples of this process can be seen in Appendix 9.

The aim of this analytical process was theoretical saturation through constant code and category construction and theoretical sampling (Charmaz, 2014), until "gathering more data reveals no new properties of a theoretical category nor yields further insights about the emerging grounded theory" (Charmaz & Henwood, 2017, p.240). However, time constraints led to only partial achievement and some codes were more saturated than others. Theoretical sampling meant that the codes constructed from the initial data led to the reformulation of the initial research proposal, including the interview schedule, recruitment criteria, and literature review. For example, the interview schedule was adapted to include focused codes such as

"taking hints and reading between the lines" which led to questions about communication, language, permission and taking the lead and associated codes and categories. As seen in the analysis and discussion section, that initial code finds a good framework within CHAT and therefore is one of the most theoretically saturated concepts.

2.7.3 - Memo writing

As previously mentioned, notes were taken during the interviews (see appendix 11), and some were treated as memos and further explored as possible categories. "Memo-writing involves writing analytic notes to oneself throughout the research process to raise the analytic level of the emerging theory, identify tentative categories and their properties, define gaps in data collection, delineate relationships between categories, and engage in reflexivity about the research process. Memos become increasingly theoretical as analysis proceeds" (Charmaz and Henwood in Willig & Rogers, 2017, box 14.1).

The researcher used Atlas.ti to store and develop some memos but relied mainly on the written research journal to explore ideas and draw possible relations between memos, codes, and literature concepts (Appendix 10). According to Charmaz (2014), memo-writing constitutes an interactive space to engage, explore, and discover theory from codes. Hence, there is no single memo-writing method. As mentioned above, Atlas.ti, the research journal, side notes, category drafts, and literature notes all served to write and develop memos with a few examples shown in Appendix 10. For example, one can see the concept of dialectics appearing in a memo interview and again in focused coding (Appendix 9) and in memos shown in Appendix 10. The idea of dialectics was theoretically associated with the dialectic materialism of Russian psychology and CHAT and made its way into the title of the model associated with navigation and frontier.

2.7.4 - Constructing the theoretical model

As seen above, there is a divergence of perspectives among theorists regarding the nature and process of theory construction. The researcher intended to adhere as closely as possible to Charmaz's (2014) suggestions, taking theory as a construction rather than as a descriptive analysis of human experience. Therefore, "after establishing some tentative categories, we conduct theoretical sampling to collect more data to fill out the properties of a theoretical category, find variation in it, and delineate relationships between categories" (Charmaz & Henwood, 2017). For example, in the early data, the idea of trauma as an opening emerged, and this concept was further explored in subsequent interviews. The researcher initially found the concept relevant but struggled to comprehend its significance or correlation with other emerging categories. As additional data were collected, other categories emerged that emphasised the dynamics of power in therapy and the potential for re-traumatisation through the exploration of sexuality and neglect through avoidance. Memos of dialectics and negotiations were created and compared with the focused codes and emerging theoretical categories. Eventually, some of the initial codes and memos around trauma became part of the category "co-creating personal meanings around sexuality".

The theoretical model was reformulated and refined several times (see Appendix 11), with categories appearing and disappearing, renamed, and reshaped in the process of theoretical sorting and integration (Bryant & Charmaz, 2019; Charmaz, 2014; Charmaz & Henwood, 2017; Willig, 2022; Willig & Rogers, 2017). The construction process continued through the writing and rewriting of the thesis, with the grounded theory becoming clearer and stronger with each rewrite. As seen in Appendix 11, the table of categories and codes was changed several times, with codes moved and renamed. This process was concomitant and dependent on the evolution of the pictorial model and by then the idea of dialectics had been absorbed into the model, presenting as in/out, I/they, pushing/holding back, etc.

2.8 - Methodological reflection

My interest in social constructionism, postmodernism and critical psychology began 20 years ago when I was introduced to the works of Mikhail Bakhtin, Lev Vygotsky, Alexander Luria and A.N. Leontiev. Their theories on neuropsychological development, learning, language, and human psychology helped me to understand dialectics in modern psychology, such as individual/social, internal/external, and biological/learning. My training was positivist and quantitative, but my 'real' understanding of psychology was marked by those ideas. My choice of methodology was guided by my initial research question, which was influenced by my broader understanding of human psychology and knowledge as a construction.

Aware of CoP's emphasis on pluralism, I found qualitative methodology easy to align with. However, adhering to CGT epistemologically and practically proved difficult. Initially, I found CGT interesting and non-prescriptive, but Charmaz's explanations of the model and procedures were confusing. These difficulties were obvious in the way I initially presented the model and evidenced the analytic journey. Despite my worries about adhering to the model, I was reassured that each grounded theory study has its specificities (Charmaz, 2014; Morse et al., 2021). With difficulty, I became more tolerant of uncertainty and comfortable taking ownership of the theory, that only retrospectively I can see how imbedded in CHAT it was.

There were difficulties with recruitment, partially caused by the pandemic and partly caused by the initial restrictive criteria. Retrospectively, the study's design was affected by my exposure to other qualitative research models, as I initially prioritised consistency over diversity by concentrating solely on counselling psychologists based in London. This was reflected in the change of recruitment criteria explained above, which then elicited other challenges such as similarities and differences between therapists' professional identities,

practice and training. The model and its categories, particularly those pertaining to training and sexuality mapping, mirrored this diversity of experiences.

Another issue with recruitment was that colleagues' enthusiasm did not translate into practitioners' interest, which could be due to various reasons. The pandemic and practitioners' availability likely played a role, but some prospective participants also indicated that this was not a theme in which they were interested or found relevant in their practice. I wrote memos about it and theorised that perhaps sexuality "doesn't come up" for these therapists because of those dialectical processes highlighted above. For example, therapists never worked through their discomfort with the subject, or their chosen models of work are themselves limiting. Retrospectively, it would have been useful to interview them to better understand the processes at play when therapists do address sexuality, adding to the saturation of categories around discomfort, avoidance, possibilities and boundaries.

Given the literature on intersectionality and GSRD and particularly issues of race, culture, colonialism, power, class and Queerness, it was perhaps a missed opportunity to not have included specific questions in the interview schedule related to this or recruit with these characteristics in mind. The intention was to be inclusive and invite all therapists to participate and all participants to disclose what felt most relevant. Still, some authors (e.g. S. J. Ellis et al., 2019), make the point that perhaps marginalised groups need a different approach when recruiting, which I did not consider and might reflect on the sample's lack of diversity.

Given the literature on therapist's experiences of sexuality training (Abbott et al., 2022; Canvin et al., 2023; Carrington & Sims, 2023; Giami & Pacey, 2006; Mollen et al., 2020; Mollen & Abbott, 2022), it would have been interesting to collect and interpret data about year of qualification and experience gained before and after. For example, the requirements to qualify as a CBT therapist are very different from a clinical psychologist. Equally, some CoPs

will have qualified through the British Psychological Society independent route which likely will yield different experiences compared to those who trained in a university setting.

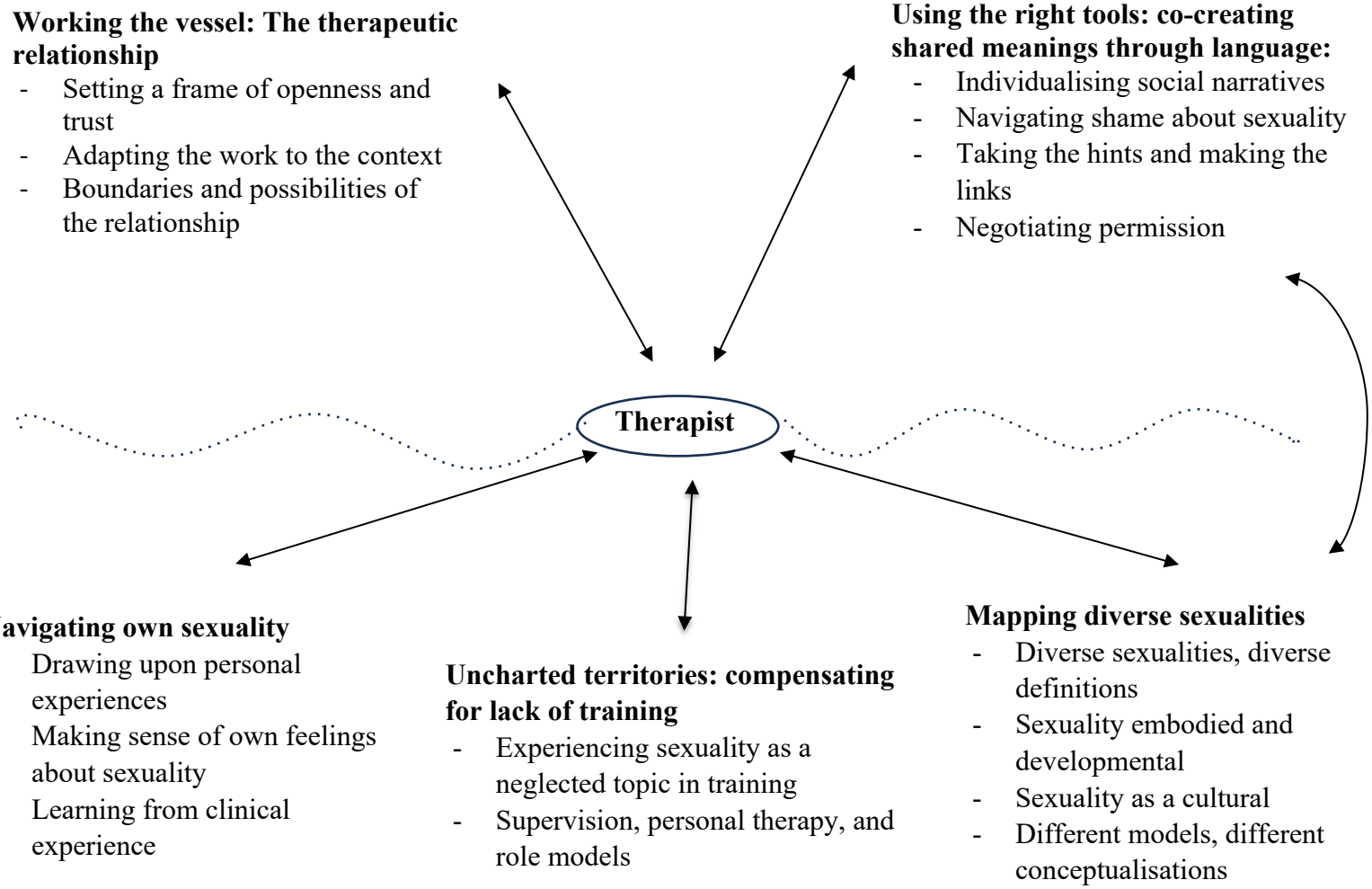
Some participants expressed uncertainty about participating in the study because they did not know what to expect from such a broad question. Although I considered specifying sexuality, keeping it in its original form allowed participants and researchers to construct their own meaning. By keeping it general, we were able to discuss several processes and elements that would not necessarily emerge if I were focusing on a specific area of sexuality, such as sexual behaviour, sexual orientation, gender, or sexual attraction.

The limited number of interviews raised questions about theoretical saturation and the quality of the resulting theory. These methodological limitations are partly due to difficulties with recruitment and time constraints. For instance, a year passed between the first and last interview, and I spent around two years analysing the data, leading to fatigue during the write-up. Part of that time was spent learning about CADQAS which although very useful, I did not make full use of and was time consuming. The fatigue also interfered with the ability to lift the model theoretically, associated with internalised messages discouraging the use of theories and literature associated with CHAT.

Despite the challenges, I enjoyed conducting interviews and learning about other therapists' work on sexuality. It has changed my practice and myself as a therapist.

Chapter 3 – Analysis and Discussion

3.1 - Overview of the model: navigating the frontier in Sexuality



3.2 - Theoretical model

From the analysis, the researcher constructed a model that explains how therapists address sexuality in therapy: "navigating the frontier of sexuality".

The model (Figure 1) tries to depict addressing sexuality in therapy as an old navigation map. Each map is unique with both challenges and opportunities for change. At the centre of the map is the therapist, the subject of this research, acting as a gatekeeper and enabler of sexual

themes in the therapy room. The line that separates the therapist's personal space and the therapy's shared space is porous to denote how interpsychic and intrapsychic, individual and social, and personal and professional processes influence each other. Although the development of this theory was grounded in the data gathered with participants, it is saturated with cultural-historical psychology concepts, theories and ideas. For example, the idea of frontier is undoubtedly related to Vygotsky's idea of border which in Portuguese and Spanish translates as "frontier" (Vygotski, 1982b; Vygotsky, 1931a, 1931b). As illustrated in the next sections, many other concepts and ideas such as use of language, meanings, co-construction, development and emotions are considered within this psychological model.

In keeping with the nautical theme, the diagram tries to convey that addressing sexuality in therapy is like the visible part of an iceberg. The largest and undersea portion relates to therapists' own experiences of sexuality, experiences of training and how they conceptualise sexuality. Therapists map sexuality as diverse, embodied, cultural, developmental, and integral to identity and well-being. The lack of training leaves therapists feeling as if they are navigating uncharted territories and relying on personal therapy, supervision, and role models for guidance. Therapists draw on their personal experiences, make sense of personal feelings about sexuality and learn from their clinical experiences to address sexuality.

In the therapy setting, therapists aim to align their tools to clients' needs, co-creating meaning around sexuality, challenging social narratives, and addressing shame. They must pick up the client's hints and facilitate links, but only after successfully negotiating permission. To navigate these processes, therapists rely on a strong therapeutic relationship which they build by setting a therapeutic frame of openness and trust and attending to the therapeutic process with its limits and boundaries.

Next, I present the theoretical model in a detailed and narrative manner using participants' discourse followed by an analytical discussion using theoretical concepts largely drawn from CHAT.

3.2.1 - Navigating own sexuality

During the interview Alexandra spoke about her "own mad journey" to addressing sexuality as she does now, and this seemed to encapsulate an important sense of personal journeys with sexuality.

3.2.1.1 - Drawing upon personal experiences

In one form or another, all participants referred to their personal experience of sexuality. For example, Heather reflected that her "parents are sort of children of the 60s. They're very sort of left wing, very liberal and very open about talking about sex and sexuality (…) I think it's an aspect of parenting they did so well". She suggests that "they just really conveyed genuine openness. And liberalism, that this is kind of, there's a complete lack of shame narrative".

However, this experience is not shared among therapists for whom "talking about sex was always taboo. And in my culture, so I think it was very difficult" (Nanda). Summer reveals a similar experience:

> I grew up in a very religious family, was before the time of the internet. I mean, thankfully, my mother, she was a bit more of a progressive, but when I was starting to go into puberty, with all of us, she would have a conversation about sex, but it was pretty much 'this is how it works'. And I suppose there was always the idea that I will be in a monogamous relationship. (…) When I was growing up, (…) my puberty, that was the idea that was around at the time.

Hence, therapists' interactions with their family and peers impact how they approach and discuss sexuality.

> (…) then as I got older, I kind of had older, more mature friends who were a lot more open to talking about sex. And then, you realise this is not as taboo as it was in my mind. So, I think that also contributed to feeling more able to discuss sex. (Nanda)

From the statements above, two aspects are relevant: personal experiences and culture. Although culture's role will be further explored later, therapists examine its influence on their sexuality. Nanda suggests “that the British culture is very stiff upper lip. And everything's very private”. Anna J shares a similar view:

> I think that we are not very comfortable in this country talking about sex and sexuality. I think there's been a huge shift in my lifetime. But I don't think it's something that we do in a sort of easy way. So, I do think culture is relevant. And I'm, yeah, I'm mindful of that sort of awkwardness, that a lot of British people might have.

Sabrina compared this with her “experience that Germany is culturally more open to sexuality”.

Some therapists indirectly reflect on their cultural and social backgrounds by raising awareness of how their experiences differ from their clients: “When we work with couples and there are conversations about sexual experiences and beliefs and ideas about sexuality, sometimes it's quite closely connected to their cultural beliefs. And sometimes those cultural beliefs might be very different from my cultural beliefs” (Summer). Lucy describes a similar awareness when working with clients from other cultures:

> I'm just not from their background as well. So, I can say, you know, ‘it's not your fault. You didn't deserve this’. But that's just not the narrative they grew up with. I'm from this other place. Now. There's part of this culture that they're now in that they feel very distant from and I'm telling them my ideals and my views and values, (…).

Interestingly, therapists are self-aware and reflective about their cultural backgrounds, as Anna J illustrates: “I think I'm informed by my background and my culture. Although I try not to be”.

3.2.1.2 - Making sense of own feelings about sexuality

While reflecting on their personal journeys, participants reflected on how they made sense of their own sexuality, feelings about it and how these might influence their work.

Awareness of one’s gender, sexual orientation, and behaviour can trigger feelings of discomfort or anxiety when addressing sexuality. Sam reflected: “Yeah, I mean, probably in my private life, I'm quite prudish. (…) Vanilla would be the description. Right? So yeah, so in that sense, (…) I can feel quite uncomfortable when people tell me things”. Lucy describes a situation when she was wearing a rainbow lanyard and wondered how she was being perceived by the client “because I'm heterosexual. And I felt, I felt a bit uncomfortable”. Anna J. echoes: “I suppose my lived experience would be something that, you know, as a straight woman would be, I would feel more informed by”. Mike also suggests that personal lived experience of gender, sexual orientation and non-normative relationships is intrinsically linked to his clinical practice and feelings arising in it: “(…) putting my personal life, I'm in a heterosexual facing relationship, but it's, it's technically an LGBTQ relationship, because of my partner's sexuality”.

Reflecting on how personal experiences connect with feelings about addressing sexuality, Carol communicates.: “I had fertility treatment for my children and so when I work with women you know, experiencing fertility difficulties (…) I can definitely feel a difference in that work and feel impacted by that pain in a different way”. Lucy makes a similar point about the times she was pregnant.

Some therapists shared their experiences of sexual trauma and its influence on how they approach sexuality in therapy. Sabrina candidly recalls an experience of therapy as an adolescent:

> She [the therapist] basically then told me that what I've experienced is sexual abuse. And, at that time, that hit me quite hard. (. …) And then she shared it with my parents. And I felt very, very, quite ashamed. And they also didn't really bring it up. And, and so it's kind of like, it's a bit of a taboo. And I think this kind of experience, of how much remains with me (…).

Alexandra reflects on something similar: “Because I'm a trauma survivor, myself, I, it probably was even why I became a psychologist in the first place”. She explains further: “you will be better prepared, in my view, or quite upskilled, because you have these living experiences, or you understand things from a different scope”. For Heather, her personal experiences led to “a sort of openness (…) it’s quite nice just occupying quite a relaxed position”.

The idea that frequently emerges is that sexuality provokes certain emotions that require processing. As Anna J suggests:

> I think it's something that people sort of joke about, you know, making innuendos about, I think there's a general, in our culture, there's a sort of unwillingness to sort of fully absorb it into daily life in the way you absorb other things as acceptable. I think there's a lot of discomfort about it.

Sam agrees when thinking about his initial experiences: “So you know, if it was brought up, I would be squirming. Internally squirming a bit, you know. It was not an area, which I would be very comfortable”.

Some participants linked discomfort to specific emotions, as Sam exemplifies in his work with sex offenders: “I have to admit here, you know, there's a part of me that's quite sometimes quite disgusted”. Summer “felt anxiety at that time when they were talking about

it", referring to polyamorous relationships. Carol equally recalls when she started working with men and sexual dysfunction:

> Initially, when I first started doing this work, it was something that I felt a bit nervous about, I think in terms of kind of how am I going to be able to kind of relate to this and don't feel comfortable in talking about this.

Perceived lack of knowledge can be a source of anxiety, as Carol illustrates: "it was just my own anxiety, really about kind of getting it right and giving people the right advice". Lucy reiterates: "I feel kind of anxious sometimes about my knowledge, of all gender issues, I suppose on sexuality issues, and I don't feel kind of fully versed in it, I suppose".

Examining the emotions mentioned is crucial since unaddressed discomfort may result in avoidance, as Anna J explains:

> I was asking him how his week had been, and I was obviously sort of avoiding it. And he said, 'are we're going to talk about what happened to me?'. And I felt really awful, because I knew that I was uncomfortable about it.

Nanda recalled similar issues and how therapist avoidance can lead to deprivation:

> I felt discomfort so, we didn't necessarily pay a lot of attention to it. But I guess after being more aware of that, I felt more comfortable and confident to kind of address it heads on. Because actually, it kind of felt like there was some sort of deprivation going on in the room where I was depriving him of being able to talk about this thing because of my own discomfort.

Mike brings the cycle of discomfort, avoidance and secondary feelings together:

> Or maybe I don't want to go there with that polyamory thing with that client, for example, that is slightly embarrassing, so that's not nice, it's those feelings where it is not nice, it's a bit shaming, is quite deskilling. It feels sad, it's upsetting.

Difficult emotions can equally arise from within the therapeutic relationship. For example, Heather remembers: “So then I felt uncomfortable, I felt that I was being kind of coerced into a sort of sexual dynamic and wondered how to address that”. Sam shares a similar experience:

> So here, when we talk about sexuality, it's shot through aggression. (…) So, they openly, you know, try to make me feel uncomfortable, I'm sure. And I think the dynamics is not so much about me, but it is that they're trying to elicit some response.

Working with trauma and sexual violence triggers strong and uncomfortable feelings. For instance, for Mike “it's always hard, because I've subsequently worked with other male perpetrators of violence, and it never feels good. Is it just because you're trying not to judge somebody. When you kind of are”. Others recall “the first time I ever interviewed a paedophile. I had to go home and have a bit of a shower. I had to get rid of him. For my mind” (Sam). These uncomfortable feelings can arise even if one is “fascinated about the world of the perpetrator” (Alexandra).

Then, for participants, managing difficult emotions becomes the challenge. Anna J suggests that one must: “sit with that discomfort and really try and understand it in a curious way. And not to be threatened by it”. Hence to address sexuality, therapists must confront their discomfort. As Sam noted: “I always feel a bit of anxiety. But then I power through and say, ‘well, I'm just I'm going to ask this question’”. Anna J similarly reflects: “I still would find that uncomfortable, I think, to this day, but I would really have to sort of muster up my courage and say: what's going on?”.

3.2.1.3 - Learning from clinical experience

Although, the process of gaining confidence to address sexuality is particular to each participant, Mike points to two important factors: “clinical work, personal experiences”. On a similar note, Sabrina explains:

> I always find myself, although I feel like in theory, I have been thinking quite a lot about it, … feel a bit, like a novice? Like I have not done this before, like every time kind of, comes to that point where I feel... actually ... I'm not 100% sure about what's best to do.

Sam makes a distinction between comfort and confidence and suggests that when working with risk and sexual abuse:

> It's not something I'm ever going to be particularly comfy about. If I become comfortable with it, I think I would have severe problems. (…) That means you're not capable of assessing risk, right for one, let alone what they might mean about my own problems.

While some discomfort and curiosity can be helpful, confidence in one's knowledge and abilities remain crucial. As Nanda describes:

> I’d like to think I’d go there now. I mean, I wouldn't know until the situation arose. But I'd like to think that it felt much more confident and comfortable to be able to explore that with the client now.

Anna J elaborates further: “I'm not saying it's easy, but I think with practice, and experience, and really good supervision [it is possible]”.

Nothing is more important than clinical experience “because I think you can read about these things, and you can read about, but actually practically, addressing it in a room, I think is very different” (Sam). Anna J. describes that “just having more hours under your belt, you

know, just feeling like you can cope with, with situations and scenarios in a very different way than I mean, I was very anxious when I started out as a therapist.". Heather agrees:

> Having more experiences of being in a room with clients, whatever they talk about is more experience, and people talking about things and expressing, and then having a range of reactions. (…) have more of a kind of sense of inhabiting my own self, which I think gives us a sort of groundedness. And a sense of kind of, well, they'll always be an element of myself in the space, it's always going to be me as the therapist, and people are gonna react in different ways.

Alexandra reinforces the importance of clinical experience and being in the room with the client:

> When we're talking about sexuality, I learned a lot with my patients, I learned about the intensity, I learned about what actually, what they want, and where they want to meet, even things so simple as setting up the therapeutic room.

Clinical experience equally contributes to flexibility: "I have to deconstruct everything again, and the more I practice and the more I see, the more I come into contact with, less rigid conceptualisations I make" (Alexandra). As we see further, clinical experience is often a necessity "because it's not something that I've been trained on. In my core training, say, I think it's been experience (…), just clinical experience, I think" (Mike).

Summer emphasises that is not just the experience of therapy but overall professional practice as her "nursing career has a big part to play in that". This is important considering the diverse career pathways in therapy and the different skill sets professionals bring with them.

Importantly, confidence and comfort are developed not only in client contact, but also through upskilling in various aspects of sexuality. Nanda emphasises that "there is something about when you write about a client and you formulate any case study like, there is something, there is a confidence to be gained from seeing your blind spots in that process". Mike reiterates:

“I think, upskilled myself, I've tried. I've done extra reading and work around working with gay and bisexual clients”.

3.2.1.4 – Theoretical framing

This first category relates to how therapists use their personal experiences to make sense of sexuality. Although some of those experiences were empowering and liberating for Heather, for others, they were negative and even traumatising. This can be connected to the concept of “wounded healer”. Alexandra suggested that her early trauma was one of the reasons why psychology appealed to her and, to some extent, sexuality. This is in line with the literature on the concept of wounded healers which suggests that most therapists have had adverse experiences and suffering, most likely in early childhood (Barnett, 2007; Sussman, 2007; Zerubavel & Wright, 2012).

Catherine Butler and Angela Byrne (2009) suggest that therapists need to examine their own ideas and feelings about sexuality and how they might work with clients with social and cultural experiences different or like theirs. All participants reflect on how their characteristics interrelate with the client’s and how navigating their own experiences informs how to address sexuality in therapy.

Cultural-historical theorists argue “the human mind to be the product of the historically evolved culture of a society. Culture not only creates goals, values, norms, and traditions, but also the very *structure of human psychological processes*” (Venger & Morozova, 2014, p. 403).

Heather reflects on her liberal upbringing which positions individual experiences of sexuality in social, religious, and cultural contexts. Participants’ views are reflected in the literature. For example, Mair (2010) argues that:

> (…) individuals with strongly religious backgrounds have a dominant narrative or life story underpinned by clear moral codes with specific prohibitions about certain sexual

acts. These codes and prohibitions may clash with more liberal narratives of sexuality in the surrounding social environment. (p.157)

Summer examined how growing up in a religious, heteronormative cisgender background might have influenced her experience of sexuality when she first trained. This is an important because studies such as that of Drinane et al. (2022) point to variance in therapy outcomes, depending on elements such as sexual orientation. However, Sam "would say some of the best work I've done was with clients who, who are not my sexuality" and Anna J reflected that '[someone] who's 18, they might not be able to relate to me, and I might not be able to relate to them etc. Or a gay person, and I might have a bias about their behaviour".

Gender also plays a role, for example Sam and Mike are careful with not "intruding" when addressing sexuality with female clients, while female therapists focus on their discomfort in addressing sexuality with men, in some cases having felt unprepared or in a somewhat lesser position. Unfortunately, there is little research on the interactions of therapist and client characteristics, namely gender, age and sexual orientation and the available research is either theoretical, based in therapy outcome measures or client perspectives (see D. M.-J. Barker, 2017; Blow et al., 2008; Gehart & Lyle, 2001; Seidler et al., 2022).

CHA theorists defend that "the system of values in various cultures is radically different", however this is only an issue if therapists stick to the erroneous idea that therapy and sexuality adheres to universal values and processes (Rey, 2009; Venger & Morozova, 2014). Therefore, it is not necessarily about the client but how therapists navigate their cultural-historical identity in relation to the clients in every therapeutic encounter. Psychoanalysts such as Ann Pellegrini and Avgi Saketopoulou (Saketopoulou, 2023; Saketopoulou & Pellegrini, 2023) make a similar point when discussing gender, identity and trauma.

Although participants readily disclosed personal information during the interviews, the literature indicates that therapists tend to avoid self-disclosure around their sexuality and other

areas of their lives (see Elder, 2005; Farber, 2003; Lea, 2009; Stricker, 2003). Mike highlights his race and disability, while Lucy highlights her pregnancy, and all therapists discuss the impact of power relationships on their comfort and confidence in addressing sexuality. Therapy sessions can sometimes involve unwilling self-disclosure, which may cause therapists to feel vulnerable and anxious, potentially due to the influence of outdated psychoanalytic theories (Farber, 2003). Participants making disclosures to the researcher indicate that participants might have seen the researcher as a peer instead of someone in a position of authority. Charmaz (2014) highlights the possible relationships of power in the research process, inviting the researcher to reflect on them and use them to construct the theory. These ideas are further discussed regarding training and the therapeutic relationship.

Throughout the interviews, participants referred to feelings that need working through to be able to address sexuality. The importance of this concept is twofold. First, it was commonly accepted by participants that sexuality is an uncomfortable topic that generates feelings of anxiety and fear. This aligns with literature highlighting that embarrassment, shame, discomfort, and a perceived lack of knowledge or competence are reasons for therapists to avoid sexuality (see Butler et al., 2009; Cruz et al., 2017; Das Nair & Butler, 2012; Dyer & Das Nair, 2013; Weeks, 2017). Although Vygostsky's and Leontiev's ideas on emotions were historically not as developed as other concepts (e.g. F. G. Rey, 2009, 2011), it is accepted in CHAT that emotions play a motivating and generative role in the individual's symbolic construction and active participation in their personal and social spaces. Hence, therapists discussed gaining confidence and comfort with themselves as practitioners and with sex and sexuality, seeing the challenges as opportunities for development.

Participants of this study, such as Summer, Anna J, Mike and Nanda, highlight how important it is to reflect on their personal values and attitudes to be able to provide GDSR affirmative therapy, following the guidelines produced by authors such as Meg-John Barker

(2017), Catherine Butler, Christina Richards and Elizabeth Shaw (2009, 2012, 2019), amongst others. Urry & Chur-Hansen (2020) research indicates that clinical practice has an impact on and perpetuates personal values, attitudes, and behaviours, while these elements, in turn, influence clinical practice, which summarises the dialect process described above.

Next, we discuss sexuality as an uncharted territory because of the lack of meaningful and consistent training.

3.2.2 - Uncharted territories: compensating for the lack of training

Therapists often rely on their own learning and experiences to address sexuality in therapy. This may be due to the neglect of sexuality in training and the need to compensate for it through personal training, supervision, therapy, and the use of role models.

3.2.2.1 - Experiencing sexuality as a neglected topic in training

Although "training is vital" (Alexandra), it is almost completely absent for some:

> Oh, I can't actually remember, if it concretely came up, to be honest. (…) But I think it has not been formally a specific part of training. Other than thinking about trauma, or talking a little bit about sexual orientation, of course. (Sabrina)

Similarly, Heather suggests "that on the training, there was a module on. I can't even remember what module it was on. But there was, I think, a session specifically on sex and sexuality". On sexual orientation, gender, and polyamory, Mike is "very aware that there's no core training where it probably could be or should be". Heather, reflects that sexuality "it's sort of, we've had a session, but I mean, it doesn't really scratch the surface. (…) So it's sort of covered, but I think, quite siloed."

The model of therapy and institution of training seem to play a role:

> Systemic training has helped a lot. Because I think, as a systemic psychotherapist, you have to think a lot about your own beliefs, your own ideas, your own experience. And as, as a group, even in training, we were encouraged to talk a lot about our experience and to share with one another (Summer).

Participants with more training,

> [think] that training is very important, it's very important that we have somehow a theoretical framework to be able to work, practice safely, but also to be able to provide a formulation of what would be the problems or the dilemmas that we are discussing in therapy. (Alexandra)

For Mike, "some of the stuff that I know about Chemsex actually did come from my core training in CBT. But there wasn't much, I think it was like, it was an add on." Whereas Anna J "had some very good lectures specifically on this issue of dealing with this, with sex in the room. And we had role-plays. And it was very useful."

Insufficient core training prompts individuals to do self-directed training. For example, Carol "did some kind of CPD quite early on" and Heather refers to her "own research (…) about this idea of what clients assume about their therapists' gender and sexual identity". Nanda's "extended case study was also on erotic transference. And I spoke a lot about sexuality, sex, and talking about it in the room" and, for Sabrina "these were like additional trainings that I did". Mike, while reporting a good experience of his CBT training, agrees that his ability to address sexuality "It's definitely been more driven by me than any trainings I've done".

3.2.2.2 - Supervision, personal therapy and role models

Given the inconsistent experience of statutory training, therapists look for other resources to help them address sexuality. Supervision is a common tool:

> I could not do my practice, not just by law, not just by standards of proficiency, etc. I think in any country where I had the privilege to work in psychology, this is a common factor, how important it is for us to actually develop critical thinking and ability to reflect, all this in a creative way. (Alexandra)

Similarly, Sam suggests that "without supervision, I think that one would have been abstract, and I would have been probably quite reticent about it".

Anna J, Alexandra and Sam suggest that it is not just learning, but also "internalising my supervisor's view on this, where he was a lot more straightforward, saying, this is part of the work. And for psychotherapists not to talk about sex, then you're not a psychotherapist, was his view" (Sam). Hence supervision "is just integral, if you work with a client and there's these conversations about sexual experience, sexual identity invariably this will become part of your supervision (Summer).

Supervision also provides a space where therapists can do a "lot of unpicking" (Nanda) of material, doubts, theories, discomforts and "look at how to work through it" (Anna J). Alexandra suggests:

> It's really important to go to clinical supervision actually to understand from a more experienced and knowledgeable person, that has, most likely, more competency in the area in which you are bringing up your issues". (…) To have someone that can help you critically think, to elaborate about your own stuckness, why certain cases are more sensitive to you, to be able to keep us in check.

Therapists tend not to bring their own "sexuality into a session, because I probably haven't thought it was helpful. And I would only bring something personally and if I thought it was helpful" (Anna J). From this statement, it seems that therapists are caught in a dilemma. While emphasising the significance of discussing sex and sexuality, they were hesitant to

address it, even during supervision. As Carol clarifies: “I suppose that maybe I avoid bringing, you know those issues to supervision”. Alexandra is an exception:

> I completely reinvented myself about tics, about expressions, when to increase the intensity of the type of motivational interview we do. Why we are more or less able to hold voids of silence, how we are able to decrease, increase that intensity, how are we able to somehow not project our own internal world into that relation, that therapeutic relation. The curiosity is an aspect that we are also exploring in supervision, but mainly, how much it helps you to reflect about why you feel overly involved in cases, why is this case triggering you, why certain patients with certain characteristics.

As Heather suggests this is not always the therapist’s choice: “sometimes (I) got the sense that supervisors have themselves felt a bit awkward” and one might “feel a bit sort of rebuffed” and “I would have really liked my supervisors to take the same approach, that I strive to take, so to kind of model being open”. Therefore, supervision can also feel “frustrating, I think restrictive” (Heather) or that “there's probably a little bit of embarrassment on a tiny scale” (Carol). Mike emphasises the need of a good match between therapist and supervisor, as “my supervisor is a gay man and it's relevant, well, not relevant, but it also gives me permission to bring it a lot more”.

Therapists’ therapy could provide a space for participants to explore and address sexuality, but experiences diverge. For example, Sam “took it (client sexual attraction) to personal therapy”. Carol, however, does not “ever remember, sexuality really been addressed in my own therapy. And I don't know whether that impacts on you and, I think that's a shame, really”. This is especially important when for her “friends that might not be, you know (…) might be gay or might have (…) be different in some ways, it feels like it was a bigger part of their therapy experiences”. Hence, participants often address sexual issues, but not necessarily their own sexuality, even in personal therapy. “It's interesting, because I'm just trying to think

about whether I talk about sex in my own therapy. I think I probably have here or there, but not, not really to depth" (Nanda). Sabrina reflected during the interview:

> When I then later on continued therapy in [location], I wasn't really talking about intimacy. And I'm not sure... Yeah, I'm not sure why? It just didn't feel. Yeah, that's a good question. Why? … It was always, almost like, there was no question about it. Like, no, you don't go there?! Like, there's no option. Though, I wasn't really conscious about this. And I'm not sure where it's coming from... Um, perhaps it is kind of a way of keeping the other person at, at a safe distance, it will be like my therapist, would, yeah, move too close to me, if I were also to let them in, and into that world and that side of me and my life.

Despite not addressing their sexuality in supervision or personal therapy, therapists often view their supervisors and therapists as role models. For example, Anna J describes:

> I had therapy myself with someone who was extremely relaxed and comfortable talking about sexual issues. And she modelled for me the most amazing way of dealing with them. And, you know, naming everything being very sort of clear and upfront, not using any euphemisms, and I've taken that myself.

Occasionally, role modelling is indirect. Sam refers to "this psychoanalyst called Otto Kernberg. He's quite famous. And he was giving the kind of supervision to three American colleagues. And it was quite interesting to see how, he would relate to issues around sex", while Nanda refers to Esther Perel's podcasts, wishing for a "European therapist because I think they do tend to be a lot more direct".

3.2.2.3 – Theoretical framing

Most participants had almost no formal or experiential training in sexuality. In the newest edition of their book, S. J. Ellis et al. (2019) write: "If you are a psychology student you

will find easy to make connections between the areas covered in Lesbian, Gay, Bisexual, Trans, Intersex and Queer Psychology and parts of your course curriculum typically labelled 'social psychology, developmental psychology' and 'health psychology'" (p. 3). However, recent studies (Abbott et al., 2021, 2022; Godfrey et al., 2006; Mollen & Abbott, 2022) indicate that psychology students' experiences are more aligned with those of the participants of this study. Although training in sexuality "is vital" (Alexandra), it was often reduced to "thinking about trauma and talking a bit about sexual orientation" (Sabrina).

Similarly, there is a sense that sexuality is an integral part of life but conspicuously absent from training and often from a sex-negative perspective (assault, dysfunction) which is supported by the literature (Abbott et al., 2021, 2022; Giami & Pacey, 2006; Mollen & Abbott, 2022; Montenegro, 2015). Participants emphasise the limited focus on sexuality, yet their experiences with the subject matter are distinct and diverse and influenced by factors such as institution, training model, and timing. Summer suggests that, in systemic training, students are encouraged to reflect on and discuss their beliefs, ideas, and experiences. Anna J, training in psychotherapy, "had very good lectures on (…) dealing with sex in the room". Mike learned "about Chemsex" in his core training in CBT. However, this diversity reinforces the findings that training in sexuality is far from consistent. Berry and Lezos (2017) suggest that, even amongst sex therapists, there are inconsistencies and major gaps in training and research for therapists working with LGBT populations. This situation risks perpetuating binary, cisgender and heterosexual therapy practices.

Due to the perceived lack of training and inconsistencies across provisions, participants relied on self-directed training, personal and clinical experiences, supervision, and training. This is consistent with the findings of Urry and Chur-Hansen (2020):

> The ongoing lack of relevant training across mental health professions is not only a major barrier to improving sexual health related practice in mental health settings but

also indicates that clinicians' knowledge and practice regarding sexuality and sexual health is likely to be influenced by a range of other sources. (p. 2189)

These other sources are supervision, personal therapy, and authors who work as role models. Vygotsky talks about the importance of playing and specifically role-playing in children's development (see Venger & Morozova, 2014), Anna J. points out that "role-plays" in her lectures helped her develop imporntant skills to her future work.

Regarding supervision, experiences are diverse for participants, for Sam, Alexandra, and Summer, sexuality is "invariably part of your supervision" (Summer). Supervisors help them "develop critical thinking" (Alexandra) and "elaborate about your stuckness" (Alexandra) and to not be "abstract and (…) reticent about it" (Sam). For other therapists, sexuality, especially their own, is not part of supervision. Supervisees' discomfort in bringing up the issue and supervisors' lack of apparent openness may contribute to it, as Heather exemplifies: "supervisors felt themselves awkward". This leaves therapists feeling that they do not have permission, "rebuffed" (Heather) or restricted.

From a CHAT perspective the lack of opportunities for training and learning is especially problematic. Kozulin (2014) suggests that "ZPD is identified as a metaphorical "space" where experientially rich but unsystematic and often intuitive everyday concepts of students interact with academic concepts provided by teachers" (p.130). Thus, therapists are left with intuition and feelings of shame and discomfort as tools to address sexuality in therapy. As seen in other categories, these emotions and discomfort often go unexpressed, therefore further curtailing therapists' potential for development and confidence.

Despite the limited literature on supervisory relationships and addressing sexuality, some studies (Chui et al., 2018; Markovic, 2007; Miller & Byers, 2008; O'Donovan et al., 2011) point to the positions of power that supervisors occupy and how they can incentivise or curtail discussions on sexuality for clients and supervisees. For example, Chui and colleagues

conducted consensual qualitative research of 12 pre-doctoral students in the US and their experiences of supervision and found exactly that.

It is important to note that some participants, advocate that supervision should be about the client and hence avoid brining "something personal" (Anna J.) and that again brings us to a frontier, in this case of limits and expectation of supervision when it comes to sexuality that can ultimately limit addressing sexuality in therapy.

In this section, the model also touches on issues of self-disclosure between the supervisee and the supervisor. For example, Mike suggests that knowing his supervisors' sexual orientation and gender identity give him "permission" to address sexuality more. These experiences highlight what Stricker (2003) suggests around what messages supervisors give to supervisees when choosing to disclose or not disclose certain aspects of themselves.

The model captures diverse experiences of supervision, showcasing its potential as a valuable resource for therapists addressing sexuality, but also gaps in what they offer. From the literature, it is unclear what training supervisors have about sexuality (Bautista-Biddle et al., 2021; Bieschke et al., 2014; Carrington & Sims, 2023; Chui et al., 2018; Kapp, 1999; O'Donovan et al., 2011). Participants referred to some of their personal therapists and supervisors as 'role models' in addressing sexuality in therapy; however, finding a supervisor or therapist who openly and positively discusses sexuality seems to be more of a matter of chance than of method. If we are to agree that imitation plays a crucial role in psychological development (Kozulin, 2014), not having adequate role models can seriously impair therapists' development and practice.

The idea that a therapist can address a client's sexuality without addressing their own also seems problematic in many ways. One is that if we are to think of the therapist as a more competent other, what are they exactly more competent on? Another is therapists' reluctance to what Saketopoulou (2023) calls the bending of will or the pushing through (even seeking)

an experience of discomfort and ‘overwhelm’. One then sees a parallel process where clients do not address sexuality in their sessions, nor do therapists in their own therapy or supervision, leaving the frontier of their experience stagnant, ill-defined and possibly feared.

There is even less literature on personal therapy among qualified professionals (Daw & Joseph, 2007). Although Sam and Anna J seem to make use of personal therapy to support their personal and clinical development around sexuality other participants such as Nanda and Sabrina do not. Carol does not “ever remember really being addressed in my own therapy”. Existing literature suggests that the concepts of personal and professional development are difficult to define and that there is a massive variation in how trainees and qualified therapists make use of them (Gallagher, 2014; Norcross, 2005). Continuing professional development, supervision, personal therapy, and training in sexuality are uncharted territory, given that so little is known.

3.2.3 - Mapping diverse sexualities

In this theory, mapping is used to describe the participants’ efforts to define the subject at hand: sexuality. Despite individual differences, participants agreed that sexuality is a complex and essential aspect of human experience and identity, shaped by psychological and medical models, as well as cultural influences.

3.2.3.1 - Diverse sexualities, diverse definitions

By starting with “quite an open question” (Sam), participants relied on their work context and experiences to define sexuality. For example, for Carol, working in a physical health setting, sexuality:

> [has] quite a specific focus, I guess, because it's often about the impact of people's treatments and things like that, that can have an impact on people's sense of sexuality. So, it can be quite specific in that way.

When asked the opening question, Nanda "was thinking about sex in the room, as well as sexuality. And I was thinking about what that's like for me and how I address sex, because actually, that in itself can be quite difficult". For Heather and Mike their work in sexuality and hence their conceptualisation is more focused on "gender identity, but their sort of sense of who they are in their sort of physical self, who they are in relation to others and in all senses including kind of romantic relations" (Heather). Lucy also "thought that you'd kind of said about sexual orientation".

Summer considers clients' "sexuality, but also their sexual experiences", while Sabrina was "thinking about sexual relationships that the person has. And in any form of sexual contact, or perhaps also sexual orientation". Anna J works

> with quite a lot of transgender clients. So, there's that issue of sexuality and how they see themselves as either male or female. But then, also in terms of how they are as sexual beings. Whether they're in the sexual relationship and sexual difficulties.

For both Anna J and Sam, working in forensic settings, sexuality can often be "shot through aggression" (Sam) which does not necessarily come up for other therapists "working in the community" (Anna J).

3.2.3.2 - Sexuality embodied and developmental.

What all therapists seem to agree on is that "sex is at the centre of our identities" (Alexandra) and that "sexuality is part of human development, psychological development (Sam).

When sexuality is conceptualised in this way, trauma can stunt or harm that development. As Alexandra puts it: “identity will be disrupted at the initial phases of your life”

> because, obviously, if you've had a sexual trauma, it's very difficult to then go on to have healthy sexual relationships (…) When your body has been so traumatised, and you know, somebody being sexual towards you is so triggering (…) so challenging to then grow up having a healthy identity and a healthy sense of enjoying sex and enjoying your sexuality and feeling able to explore that. And that being a kind of safe part of your identity is very difficult. (Lucy)

Sexuality is inherent to the body, as Sam describes: “a lot of the way the mind works is bodily and sexualised”. Alexandra, working in a sexual health setting, agrees:

> Psycho sex mostly relates, is a very short approach around relation with body, can be someone that, for instance, does not feel comfortable, or have an erection, people with low libido. Or on the other side of the spectrum, with deeper arousal, we have disorders, such as nymphomanias and addictive sexual behaviours that ultimately put the person at severe risk.

This excerpt points to sexuality being perceived as a pathology or problem, perhaps influenced by the prevalent medical model. Carol, working in a physical health setting, highlights the tension that can occur between medical and psychological models of sexuality: “There is that kind of therapeutic aspect and medical aspects and how you kind of negotiate that is, yeah, it's a challenge”.

3.2.3.3 - Sexuality as cultural

For most participants, “culture is relevant” (Anna J). Sabrina highlights that “there are a lot of misunderstandings around sexual violence, and I think culturally...Yeah, that a lot of myths are still being fed in by society”. Heather, Alexandra and Mike reflect on similar ideas

around culture and the impact on addressing sexuality. Summer highlights the process of working with different cultural and social references: “If you think about cultural and social narratives around talking about sex, sometimes you've got a man that's in his 40s 50s 60s. I've worked with a couple in their 80s. And how do you then talk about sex?” Sam agrees: “I'm affected by the society, (…) even if we just if you was talking to me, and we were around in 1956, or something, I think we'd have a fairly different conversation about lots of these things”. Heather indicates that perhaps it is easier to have “discussions about (…) kind of social narratives and context (…) Clients who potentially, especially younger clients, I guess who have grown up through a span of narratives around sexuality and gender becoming much more prominent and much more nuanced”.

Some social narratives can be seen as detrimental to the expression of sexuality, for example:

> the culture around shaming, and the rejection, the trauma that is created, within the families, push people to situations of risk, increased risk, and do not let them develop a natural sense of identity that opens to curiosity, to exploration, to acceptance. (Alexandra)

There is sense of tension between what is “the body, the biological, the drive, the instinct” (Sam) and a “span of narratives around sexuality and gender” (Heather), for example “this idea of toxic masculinity” (Mike) or what is “happening within the black relationship space” (Mike). Therefore, therapists often engage in “discussions about social narratives and context” (Heather), being aware that these “social dominant narratives (…) can constrain certain conversations” (Summer). Alexandra describes the intersection of culture and body, almost as opposing forces:

> So, if we think in a moralistic way somehow, by pressures of family, (…) by pressures of society, either in terms of the pull of trauma, that identity will be disrupted at the

initial phases of your life. And this will enable that you do not have a great relation with body, mind, and soul.

Although this idea is further developed when we discuss the creation of shared meanings, therapists generally address this tension by "non pathologizing" (Carol), being "quite integrative, (…) very, very person centred", (Anna J) and taking a holistic approach, looking at "the entirety of that person" (Sam).

3.2.3.4 - Different models, different conceptualisations

When it comes to defining sexuality psychologically, there is some diversity among participants relating to the models of therapy they ascribe to. Sam conceptualises "sex, sexuality, sexual force as a drive" regretting "the relational turn in psychoanalysis" which was the focus of Carol's work in a psychodynamic service: "relationships were a real focus in that aspect, but not just on sexual relationships, I think a lot about kind of childhood relationships". Heather having worked "with people who are more psychoanalytically oriented, and they talk about certain aspects of sex, all the time", however she points out to a tendency to over emphasise sex and suggests that "sometimes a cigar is just a cigar". She goes on to highlight that at least in psychoanalysis there is an "overt theorizing around sexualization", which is generally absent from other models of therapy such as person-centred and CBT.

A question arises from this tension: does a therapist need to be "taught a particular approach that's distinct for sexuality (Heather)? The assumption is that depending on the model, therapy will focus on different areas, and the process will be different. Nanda makes a reference to this, "as a model I struggled with DBT anyway, but I had a client who was identified as lesbian. (...) Yeah, I didn't know where the space was to bring it in". Mike questions: "Is [sexuality] something that always needs to be addressed? So, as a CBT therapist, I think it's not" although, is it "something that comes up a lot of the time? Yes", especially related to

trauma and use of EMDR. Given these questions and doubts, most therapists seem to adopt integrative or pluralistic approaches as Anna J describes: “I use all sorts of different models when I'm working. And it really does depend on who I'm working with and what I think might be effective.”

3.2.3.5 – Theoretical framing

Although not necessary, having a map can help when one sets out on a journey. How do therapists conceptualise sexuality? Participants suggested that sexuality can refer to “sexual relationships” (Sabrina), “sexual experiences” (Summer) “sex” (Nanda), “gender identity” (Heather, Mike) and “sexual orientation” (Lucy). However, different therapists, authors, and researchers tend to focus on different areas of sexuality, prioritising one aspect of sexuality over others and struggling to come up with a wide coherent picture. As seen in the literature review, there are perhaps no other area of human experience more fragmented than sexuality.

Despite an effort by the therapist to integrate the different views of sexuality, their different definitions still tend to reflect a Cartesian dichotomy between the body and mind. Goetsch (1989) took a similar approach, suggesting the usefulness of an “essentialist definition of sexuality” separate from the constructed “sexual enactment” (p.249). Arguably this is now an outdated reference, but his suggestion reflects the ongoing difficulties in defining sexuality, while avoiding reductionist or essentialist pitfalls. This is no longer an issue if sexual identity is seen as individual and social and continuously constructed in relation to the other as modern CHAT strongly advocates (see Stetsenko & Arievitch, 2004).

This lack of coherence around sex and sexuality filters into the therapeutic process, what is addressed, and what is not. As Spinelli (in M. Milton, 2014) succinctly puts it: “Sexuality is what we say it is” (p.23). Participants say sexuality is a biological, social, and psychological phenomenon that refers to behaviours, identity, and relationships. Here, cultural-

historical psychology can offer the integration that participants seem to be seeking as "this theory considers the human mind to be the product of the historically evolved culture of a society. Culture not only creates goals, values, norms, and traditions,1 but also the very structure of human psychological processes" (Venger & Morozova, 2014, p.403).

As seen in the literature review, sexology and sex therapy are well grounded in the disciplines of biology and medical science (Denman, 2003; S. J. Ellis et al., 2019; Race, 2015; Štulhofer, 2015) which further affects how participants might perceive the topic as too complex and foreign, shying away from it. Working in a physical health setting, Carol faced challenges in negotiating the medical and psychological aspects of sexuality. She finds herself discussing physical aspects, potentially at the expense of psychological ones. Alexandra, Sam, and Lucy highlight the physical, embodied, and developmental aspects of sexuality, albeit bringing narratives that presuppose the development of healthy sexuality that can be interrupted by trauma and socio-cultural issues. The idea of embodied sexuality puts therapist closer to the idea of "embodied consciousness" (Spinelli in M. Milton, 2014, p.26), albeit not fully embracing Merleau-Ponty's (1962) and Vygotsky's monism of self and other, and mind and body.

Most participants refer to "a lot of myths still being fed into society" (Sabrina). Some participants stressed the cultural aspect of sexuality which aligns with the social constructionist stance. When Heather points out to the "the span of narratives around sexuality and gender", she highlights the social construction of sexuality as presented by several authors (e.g. Butler et al., 2009; Denman, 2003; S. J. Ellis et al., 2019; Weeks, 2017). However, these views only highlight the difficulties posed by cartesian views of self and sexuality in that people are essentially born one way and changed by society which appears as potentially damaging to the individual. As already seen, several authors, from existential and psychoanalytic fields have tried to bridge this gap by speaking about "psychic reality" or "embodied consciousness"

(Milton, 2014b, 2014a, 2017; Saketopoulou, 2023; Saketopoulou & Pellegrini, 2023), however this reinforces the separation. There is a clear way to think about sexuality, self, and identity if you believe that development happens at the same time and in a space where people are active participants in their own development (Friedrich, 2014; Robbins & Stetsenko, 2002; Stetsenko & Arievitch, 2004).

While most therapists strive to work affirmatively, some still refer to sex-negative conceptualisations such as "addiction" (Alexandra) and "perversion" (Sam) which are being questioned by therapists such as Silva Neves (Neves, 2021, 2023; Neves et al., 2023a, 2023c; Neves & Davies, 2023). Issues occur when certain conceptualisations based on therapists' values and beliefs go unchallenged or not even discussed, as Butler et al. (2009) highlight.

S. J. Ellis et al. (2019) succinctly theorise the reflections and dilemmas expressed by participants:

> In contrast with an essentialist perspective, which views gender and sexuality as biologically determined or fixed in early childhood, a social constructionist perspective creates the possibility of agency. This is not the same as saying that we choose our sex, gender, or sexuality, but rather that historical, social and cultural norms make certain identities/subject positions possible – or even desirable - whilst marginalising or rendering others invisible" (p. 20).

However, based on participant accounts neither GSRD nor CHA theories are embedded in their thinking about sexuality. This compromises the commitment to social justice associated with sex positivity (Burnes et al., 2017b; Mosher, 2017), feminism, Queer and LGBTIQ psychology (Butler et al., 2009; S. J. Ellis et al., 2019) and GSRD (Milton, 2014b; Neves, 2023, 2023; Saketopoulou & Pellegrini, 2023). These ideas are filtering into therapists' conceptualisation of sexuality but as mentioned, remain fragmentated, incoherent and, hence unhelpful to therapists.

The literature review queried if different therapeutic models affect how sexuality is conceptualised and the answer is affirmative, to some extent. For example, Sam and Nanda regret the relational turn in psychoanalysis and its focus on relationships at the expense of sexual drives and behaviours. Some psychoanalytic authors have tried to reclaim sexuality into the model, as well as the inclusion of psychoanalytic theories in sex therapy and sexology, fields dominated by medical and behavioural thinking (Daines & Perret, 2000; Zamboni, 2015). It is a curious situation where psychoanalytic theory seems to dominate generalist approaches to sexuality while cognitive-behavioural models dominate in psychosexual therapy (Athanasiadou-Lewis, 2017; Daines & Perret, 2000; Peterson, 2017) As Mike suggests, it is not always clear if and how sexuality fits with any particular model, further questioning whether sexuality always needs addressing. As seen above, the answer depends on how one conceptualises sexuality among other areas of life it might indicate the neglect or avoidance of the topic (Butler et al., 2009; Daines & Perret, 2000; Denman, 2003; *Guidelines for Psychologists Working with Gender, Sexuality and Relationship Diversity*, 2019; Shaw et al., 2012). However, they can be excused given the apparent complexity and often contradictory models, theories and approaches to sexuality. Despite the difficulty in putting together a coherent map of sexuality, participants address it with whatever tools they have available.

3.2.4 – Using the right tools: co-creating shared meanings through language

Addressing sexuality in therapy involves selecting appropriate tools and aligning them with the client's needs. This includes individualising social narratives to address shame and making connections between the client's words and sexuality. As clients often do not directly address sexuality, therapists must obtain permission, work collaboratively, and scaffold conversations. All these concepts are related to CHAT, which presupposes that all human development is a "cultural evolution" that relies on the "collective and collaborative (i.e. social)

use of tools" which "reflect ways of mastering specific classes of tasks discovered in collaborative practices" (Stetsenko & Arievitch, 2004, p.482).

3.2.4.1 - Individualising social narratives

Therapists emphasise personalised social narratives for multiple reasons. Alexandra explains that "there is an enormous amount of suffering by not recognising that, for I define myself in relation as part of a system and in my body and in all these systems". She continues:

> Often, they come into therapy because (…) at some point of their lives, this is not sustainable. And there is a sense of detachment, disconnection. And they live quite a significant amount of their lives, lying to themselves, by not being able to actually stand their grounds within families, religious matters, being shamed and humiliated. (Alexandra)

Therefore, an important task of the therapist is to make it clear "that everything that they describe is a construct, a social construct, and the family construct" (Alexandra) and support the client making sense of these social constructs. Heather has a similar experience: "Some clients want to talk about very specific sexual practices that they're interested in, and how that sort of feels for them or how they feel society might view them (…) Or how I might view them."

It is a common idea amongst therapists that "it goes beyond the realm of social norms, talking about sex" (Nanda), however this is a transitional process and not necessarily an essentialist one. Nevertheless, the work on sexuality intersects with other areas of mental health and social situations leading to a reciprocal process between therapy and wider context. Summer exemplifies:

> It was around the time of COVID, he was watching much more television. He then watched programmes or the news about Sarah Everett, and he was really shocked to

> learn that there's so many women that are being sexually assaulted and murdered (…) it just became part of his, although he's got other thoughts and other anxieties, that became another part of his presentation around anxiety (. …) I spoke to him about what was the meaning of that. What is it like being a young man, and hearing these news reports, and both online, and on the television and in newspapers, as well. So, it was also about helping him to put those thoughts and experiences into a wider social context.

As Alexandra suggests, the aim is to "use approaches that help the person to build up a narrative why that is relevant". In other words, the aim is "to understand the context, where this person is coming from is really important. (. …) you're trying to see the whole of that person, including some of the really disturbing parts" (Sam).

In practice, individualising social narratives "is about mirroring, attuning in a more interceptive way" (Alexandra) and "quite a lot about normalising people's experiences" (Carol). It entails "to think about this [own views] and their context and think about their contextual influences and how come that they are thinking or behaving in this way" (Summer). It also involves "echoing language they might use" (Heather), which we will discuss further.

3.2.4.2 - Working through shame

As seen above, when therapists "think about cultural and social narratives around talking about sex (…) there can be such a link between sexual experiences and shame" (Summer). There is an acknowledgement that for most clients "there's issues about identity and difference and shame" (Mike).

For clients, feelings of shame often stem from trauma. When talking about her work with victims of sexual abuse, Lucy explains:

> [there is] lots of kind of patriarchal cultures where you're not really allowed to talk about it. Because even if you do talk about it, it's still your fault. And, you know, shame

on you (. …) Unfortunately, it is very shameful (…) So yes, some clients will come in and say: 'Yes, this, this happened to me', and they might hint at something else, 'but I don't want to talk about it'. But they might not feel able to say it.

Hence, participants need to "work through the kind of the smaller, trauma points of like, like shame and guilt" (Mike), focusing on "the shame aspect of things rather than the details of what has happened." (Sabrina)

Mike emphasises that shame is also features for perpetrators of sexual violence, as "in the society, [violence] it's not a good thing (. …) So, it's more shameful". Although working with perpetrators of sexual violence "doesn't happen very often, (…) statistically doesn't work out right". He suggests that there might be a process of "kind of self-censoring". In this instance, Mike questioned the ratio of victims to perpetrators of sexual violence, suggesting that perpetrators might avoid discussing sexual issues. Sam's experience, working in forensic settings is often different, where perpetrators of sexual violence might want to talk about sexual violence, for "perverse reasons".

Thus far, shame seems to be a barrier in addressing sexuality; however, this is not always the case. Some clients will "explicitly with some hesitancy and shame" (Mike) bring things up. Anna J from her work in prisons suggests "There's a lot of shame about sexual abuse, of course, but they're usually pretty direct" and for Sam, "lots of them [clients] enjoy telling me about their sexual fantasies, you know, they're up for talking about rape fantasies".

Although the openness is generally welcomed, in situations where the client might be in crisis, the therapist needs to "approach more in terms of stabilisation and building up a narrative around trauma (…) And then the intervention needs to be step by step and, being able to guide them through that" (Alexandra).

According to the participants, there are essentially two ways of addressing shame:

> Where there's not an emotion regulation problem, there's not a risk problem. It's just, it's lots of shame, we might be more directive. 'I wonder if this has happened to you' (…) And if people have had loads of therapy, and nothing's changed, we might be even more directive; 'You know, if we don't talk about this, then it's not going to change. Yeah, you don't have to talk about it. But more therapy is not going to help if you don't talk about it'. (Lucy)

Another method is to "go with the client and to not, overwhelm them. So, to keep also their pace" (Sabrina) or to "sit with that reaction first, rather than going to the content" (Heather).

3.2.4.3 - Picking up hints and making links

Given the sense of prevailing shame, clients often hint, as Nanda explains:

> Clients will kind of drop hints until they feel safe enough, or until you kind of address it head on. I think that's true for a lot of things. And not just with regards to sex. But I think when clients want to say something, and they can't quite find the right words. They'll drop hints. And I think sex definitely comes into that.

Sometimes, clients have yet to develop the language, as Heather exemplifies with a client "talking about being a child and sort of having a sense of not having words or having a sense of his sexuality and how it sort of family responded". She continues: "often people talk about things like 'I'm wondering what label I might apply to my sexuality'. I'm kind of experimenting with using labels or sometimes experimenting with use of language in the therapeutic space" (Heather). Other times, the indirect language might be connected to discomfort:

> He spent a very long time and really months building up to telling me about a sexual experience they've had that left them feeling very ashamed (…) So for a long time, they'd say, there's something I'm thinking about telling you. (Heather)

There is a shared understanding that clients might allude to sexuality indirectly, "sort of using innuendo" (Anna J) and that "there can be quite a lot of kind of hovering around issues" (Carol). Picking up on hints can be the first step in bringing sexuality to the forefront of therapeutic work. As Heather suggests:

> If there's a hint, I'll pursue it, and (…) I might say 'you said in bed, I wonder if you mean sexually?' (…) it's called escalating. I might bring in the word sex or sexually if I feel someone's using euphemisms. And see how that lands".

Hence, taking hints is about:

> Listening out for more for this language, basically. And I guess, it was a lot of language of an erotic nature, sometimes [they are] obvious links, as in that example. And at other times, much subtler ways that clients will kind of flirt with the idea of saying something. (Nanda)

Practically, it involves "looking at clients, their physicality" (Heather), which was a particular challenge during the pandemic "because if it's remote, it's normally always telephone, you lose a lot of the kinds of cues" (Carol).

The therapy model influences the links that are created and how. Sabrina suggests that "[in] psychodynamic psychotherapy, in some ways it might be easier to bring this topic up because your kind of like, you would just throw in some hints, and you wouldn't directly ask anything, but you would make some interpretations". Sam, who works mainly with this model indicates that "there might be a sexual undertone to things as well, that, I think that, that's obviously something that comes to my mind, this idea of the erotic transference". However, as Nanda suggests, when that happens, "it's very difficult because you also don't want to interpret

something that isn't there". Alexandra reflects further that "despite that we might think we own some truth or some knowledge around that subject. What it matters, in terms of psychodynamic approach, is where the person actually is, and be able to safely conduct these subjects". Some therapists experienced certain models (and settings) as limiting because although picking on hints, they felt that they could not ask about it. When talking about erotic feelings between client and therapist, Sam experience was that "it doesn't really allow for, it's difficult to bring that in for CBT". As seen above, Nanda had a similar experience with DBT (Dialectical Behavioural Therapy).

After picking up on cues, therapists need to link the information, sometimes on behalf of clients, as Nanda explains: "they've had these difficulties, and they can't, can't quite make the links. I think it can feel quite validating to say 'oh, I get that. That makes sense to me'" Linking information is not just about what is said but also what is lacking "because often we get to the point where like, this just doesn't make sense. There's something missing from this formulation" (Lucy). Often, it is up to the therapist "to basically put the pieces of it together" (Sabrina), even if "what I would do was park it in my own mind" (Sam).

3.2.4.4 - Negotiating permission to address sexuality.

A code that was developed early related to having permission to address sexuality if there was known sexual trauma. As Nanda explains:

> I think it's I think a natural link can be seen between sexual trauma then and sexual experiences now. So, I think it kind of I think just the mention of sex can, if the client feels comfortable enough to say, talk about a sexual trauma then I think is assumed that they'll feel comfortable enough talking about sex now, not always I'm not saying that's always the case. But I think I have permission because I think sex has been mentioned.

However, having permission does not mean that therapists will necessarily address sexuality because “it feels I'd been intrusive” (Sam) and so “we will always give them at assessment, the option, you don't have to go into any detail” (Anna J). This a way to resolve the dilemma between pushing the client or allowing them to avoid, because therapists’ overall view is that “in sexual trauma, perhaps there has already been a breach in some way” (Nanda).

Hence, “there's lots of scaffolding needed, lots of relationship building and lots of permission (Lucy). When a client is talking about trauma, Mike tells them “At some point if you want to say more about that we can. And it's kind of like that, we've named it and I'm not necessarily pushing”. Summer’s process is akin:

> I think some of our clients, particularly if they've been sexually abused, it means that things have been done to them. Yeah, it's so important for me that whatever I ask or talk about, that that's done with the consent or permission of the client that I'm working with.

Lucy, who specialised in trauma work explains that:

> we have permission to ask where maybe others feel more worried about it. And from kind of the onset on from assessment from triage, you will be asking about it. Yeah, very gently, but very deliberately. And if they say no, but it's something just missing from the formulation, basically, then we would scaffold it.

Scaffolding, “it's about recognising, as therapists, the temperature, and the intensity. (…) Try to mirror some aspects of change. But do not try to pull or open doors that they are not ready to do” (Alexandra). All therapists are very careful not to make the “client ever to feel coerced or forced” (Heather).

Scaffolding conversations is vital for collaborative work, which addresses a dilemma regarding pushing boundaries versus risking neglecting clients. As Alexandra suggests, therapists should “not pushing too much that boundary, because it can be quite destructive”. Therefore, it is about “working collaboratively together (…) it's joint work. So, I'm not the

expert, I will do what I can to help", which Mike reiterates: "I'm especially keen to be on the same pages and be collaborative, as clumsy as I can come on".

In terms of process, "It's quite a sort of sixth sense of what feels right in the moment" (Anna J), it is also about "using their language, really meeting them where they are, not sort of exploring that before they're ready as well. So, making sure there's a really good working alliance" (Anna J). The process is individualised and ongoing: "this feels like it would be therapeutically relevant, but you haven't brought it. But I'm not pained to ask because that would be very aggressive and forthright" (Heather). Sabrina summarises how "important [it is] to go with the client and to not, overwhelm them. So, to keep at their pace".

3.2.4.5 – Theoretical framing

"At the centre of Vygotsky's cultural-historical psychology is the fact that human beings are distinguished by their capacity for signification, that is their ability to use signs (words) in order to make meaning" (R. Miller, 2014, p.9).

When moving in uncharted territories with only a partial map and personal experience, therapists need to make use of the right tools to co-create shared meanings with the client. This entails individualising narratives, taking hints and making links, negotiating permission and working through shame.

Here, tools signify what Venger and Morozova (2014) call *"psychological means"* (italics in the original). Sexuality is both a biological and a social-cultural phenomenon that is shaped by psychological tools like language, which are historically human inventions that people constantly use, change, and introduce again.

Alexandra most clearly describes clients' needs to "define [themselves] in relation, as part of a system". She describes people's suffering when their sexual identity is invalidated and punished by families, religious groups, and social groups. One of CHAT's main principles is

that every higher function, including identity is social first because it is produced by historical and cultural collective practices and then becomes internal but always intersubjective (Friedrich, 2014; Stetsenko & Arievitch, 2004; Valsiner & van der Veer, 2014; Vygotski, 1982b).

Other therapists, like Heather and Sabrina, emphasize the importance of allowing clients to explore and negotiate conflicts arising from their experiences of sexuality. Allowing the client to explore their sexual identity and understand the person as an active agent of change and producer of social tools can both validate the client's experience of themselves and the world and support them to develop the means needed to change themselves and their circumstances. As seen next that contributes to CoP's agenda of social justice and best practices.

This aligns with S. J. Ellis et al. (2019) reflections on mental health, prejudice, and discrimination. Many participants mention the discrimination and violence experienced by LGBTIQ and GSRD individuals in various social settings. Therapists aim to support clients in overcoming these challenges, or as Carol suggested: "normalise people's experiences". Most participants referred to ways in which they support clients to challenge heteronormative, heterosexist, and cisgender views of sex and sexuality, which several authors have advocated as best practice (Butler et al., 2009; S. J. Ellis et al., 2019; Mcleod, 2019; Mosher, 2017). That challenge is only possible because therapists and clients collectively and collaboratively develop psychological tools that allow the person to influence themselves and the world (Friedrich, 2014). The category of individualisation of social narratives was meant to represent the process just described - that is, the person becoming an active agent of production of cultural means that will give rise to psychological, interpersonal and social change (Robbins & Stetsenko, 2002; Stetsenko & Arievitch, 2004). Hence, individualising and socialising are one

and the same process co-occurring both internally and externally as new forms of psychological activity are developed.

It is commonly agreed among participants and authors that sexuality is closely interlinked with shame. Therapists need to work through shame (including their own) so that patients can live a satisfactory and healthy sexual life. Dealing with shame links in with ideas of resilience and post-traumatic growth, as S. J. Ellis et al. (2019) highlights. These concepts have been the subject of extensive research around trauma (e.g. (Salim et al., 2023; Timblin & Hassija, 2023), which might include experiences of discrimination and invalidation and not just sexual violence. Saketopoulou (Saketopoulou, 2014, 2023; Saketopoulou & Pellegrini, 2023) recently introduced the concept of traumatophilia which sets trauma as potential for growth and transformation and not necessarily a curtailer of development and pleasure. This is an interesting idea that for the researcher relates very closely with CHAT in the context of defectology (Vygotski, 1983). The author discusses "supercompensation" as presented by A. Adler and dialectic materialism as discussed by K. Marx to posit that "defects" are not debilitating in themselves and are dynamic phenomena with great potential for creative and effective development.

Participants such as Lucy and Mike reflected on the relationship between gender, sexual orientation, trauma, and shame, asking questions that could inform future research. They emphasise the role of shame in their PTSD work, examining how cultural and gender factors impact victims' and perpetrators' willingness and ability to discuss sexual trauma. Only a few studies (e.g. Baggett et al., 2017; Kimerling et al., 2021) have looked at these issues and how sex-affirmative approaches can support the work with sexual trauma. However, participants adopt a way of working around shame which is to be "directive" (Lucy) without "overwhelming them", "sitting with that reaction first, rather than going to the content" (Sabrina). As seen in relation to the category of training, what they are describing is working

within the client's zone of proximal development (del Río & Álvarez, 2007; Eun, 2019; Valsiner & van der Veer, 2014; Vygotski, 1982b; Vygotsky, 1931a, 1931b; Yasnitsky et al., 2014; Zaretsky, 2021)

Participants stressed that not all patients were shy about discussing sexuality, they also suggested that patients' will "drop hints" (Nanda) and the therapist needs to listen "out for more of this language" (Nanda). This is what Kozulin (2014) refers to as dynamic assessment in that therapists are constantly assessing not what the client "already knows" but what is "possible for them to know". Sometimes clients and therapists lack the language and, as Heather highlights, therapists need to experiment "using labels" that feel comfortable to patient and therapist. Labels are no different from the concept of sign and tool described by Vygotsky (Friedrich, 2014). About this, recent research suggests that clinicians might avoid certain sexual themes, including LGBTIQ and GSRD because they lack the language or terminology to do so (Canvin et al., 2023; Dyer & Das Nair, 2013; S. J. Ellis et al., 2019; Hanley et al., 2023) Once again, CHAT might offer a fresh perspective on this because of the work with aphasic patients who would develop, with the support of the others, new psychological tools and skills that allowed them to communicate (Vygotski, 1982b, 1983). Hence lacking the language can be an opportunity for the client to develop their own subjective meanings and simultaneously create new cultural historical meanings available to others.

Negotiating or navigating permission is a fluid concept because it depends on the patient's needs and the context of work. Saketopoulou (2014) when considering limit consent in the psychoanalytic encounter, suggests that "the patient's original consent in that respect is in large measure naïve. (…) the analyst too is unaware of what she is really consenting to when starting treatment (p.66). In some cases, therapists, in line with what Urry and Chur-Hansen (2020) found, will actively curtail discussions about sexuality, especially if patients are in

psychiatric and crisis settings, based on the idea that it might be unsafe for the patient and therapist to do so.

A core theme is the need to constantly assess clients' abilities and circumstances and adapt accordingly. This is close to what Vygotsky (1896 – 1934) defines as working within the person's zone of proximal development (ZDP) (del Río & Álvarez, 2007; Eun, 2019; Kozulin, 2014; Valsiner & van der Veer, 2014; Vygotski, 1982b, 1983; Zaretsky, 2021). Although participants did not refer to it explicitly, when they assess the patient's level of interiorisation of cultural, historical, and social experiences and build from there, they are working within the patient's ZDP. Scaffolding conversations and matching the "client's pace" (Sabrina) while "mirroring aspects of change" (Alexandra) are common concerns for therapists. As the therapist mirrors aspects of change, the client (analogous to a child) imitates (Kozulin, 2014) This idea closely aligns with the core concepts of this theory: navigating and frontier. Both therapist and client are interlocked in flux between what is known and what is being constructed. As Valsiner and Veer (in Yasnitsky et al., 2014) describe, "the person constantly moves beyond his or her previous established state, to the areas of acting and thinking that had not yet been actualized" (p.154).

One argues that participants use a dynamic assessment as described by Kazoulin (2014) and closely connected to ZDP. If we agree with Vygotsky's position that education precedes development, matching the "client's pace" can leave therapy in a stalemate. CHAT proposes that considering the client's ZDP, the therapist might need to create discomfort and lead the therapeutic encounter to allow the client to develop.

The themes of co-construction and individualisation closely link to the next category.

3.2.5 – Working the vessel: the therapeutic relationship

This category can be a prerequisite to the previous one; however, if language and meaning are the instruments used to address sexuality, the therapeutic relationship is the vessel that enables this process. The development of a collaborative therapeutic alliance entails setting a frame of openness and trust, adapting the work to the context and defining the therapeutic space accordingly. Therefore, therapeutic relationships offer opportunities and limitations for addressing sexuality.

3.2.5.1 - Setting the frame of openness and trust

Therapists understand that if sexuality is to be addressed, they need to create the right frame or, in other words, create the right therapeutic conditions for sexuality to be addressed.

Participants stressed that "some clients who do find it, a topic that they don't want to look at. And I think when with those clients, you need to build trust. But other clients are a lot more open and freer talking about sex and sexuality" (Nanda). Participants found it "quite reassuring when people are quite practical in that way (…) I feel like it shows quite a lot of trust in the relationship" (Carol). Building trust requires therapists to "convey sort of openness" (Heather) which is shown by trying to "also formulate open questions" (Sabrina) and by showing "a very deliberately open posture" (Heather).

"Holding a genuine position of curiosity about all aspects of people" (Heather) and "be curious about people's sexuality" (Sam) is another important condition. In fact, as Summer explains: "I may have felt irritated with somebody or I felt, I lost my curiosity. That's something I'm definitely going to bring into my post session, or to supervision". Therapists should be curious, but not overly intrusive, as Heather points out: "Am I pursuing something because it feels beneficial for the client, therapeutically relevant? Or am I just being a kind of curious human wanting to know about other people's sex lives?"

Therapists strive to be "very warm, accepting, totally non-judgemental" (Anna J) because "it is important when you are forming a therapeutic alliance, that actually the patient also feel secure but feel you are authentic as a therapist" (Alexandra). Especially when working with sexual trauma, therapists tend to:

> Feel quite a profound empathy and sadness. And yes, there is a real desire to show them care. And I always acknowledge it. Because I'll always say, I'm so sorry that happened to you, that shouldn't have happened to you. Which sounds very trite. But it feels like… something. (Anna J)

As Sam succinctly suggests: "the therapeutic relationship has to be strong enough to do that [address sexual trauma].

The concepts of authenticity and empathy can be challenging, when "sometimes I don't like the people I see (…) And I can acknowledge that and still work with them. And that's, in my view, that's a different kind of empathy than the empathy of client centred person" (Sam). It can be difficult to feel empathy when clients themselves are "not expressing empathy, not experiencing much empathy, or remorse" (Mike). Even in situations where therapists are working with perpetrators of sexual violence, there are attempts to:

> Really trying [sic] hard to maintain some kind of empathetic stance, especially when I've been working with these guys being abused a lot. And, and, generally, that's the case, to be honest, that when that has happened, that when somebody's been a perpetrator of violence, it's, they've been a victim of violence as well. But it's, it really is really, really hard. (Mike)

The therapy model influences the therapeutic process and therapists' ability to address sexuality. Nanda reflected that when working with cognitive-behavioural models:

> [I] didn't know where the space was to bring it in (…) Whereas in psychodynamic or, I guess, more existential or more humanistic models, I guess, there is more freedom and

space to explore the motivation behind the behaviour rather than just focusing on the behaviour.

Sam shares a similar view but when it comes to client-therapist attraction “the model does protect the clinician, because basically, you're not you. It's not so focused on the relationship in the room. So, in that sense, it does give you that chance of opting out of it”.

Regardless of the model, safety is paramount when discussing sexuality and so the space “needs to be safe. It needs to be like a negotiated distance” (Mike). The therapist aims at “creating a space where people feel able to talk about their most intimate lives” (Carol). Safety is important to both client and therapist because sexuality “can feel very intimate” (Nanda).

Lucy emphasises safety and how the therapist role can be multifaceted when addressing risk:

> You're pushed into the safeguarding role where you're having to almost be this parent that notices where maybe someone didn't notice when they were younger, and says, something's not right here. And we need to protect you, you know, you deserve protection from this (…) yeah, it's hard to just have this therapy role where you're just being a therapist, and you're not kind of yeah, having this safeguarding role as well.

Nanda highlights the idiosyncrasies of the therapy space:

> You can create that intimate space by how you, as a therapist hold that space and communicate that client is cared for. I think therapy is intimate and everything we've talked about, it's very intimate (…) You don't talk to strangers about your sex life, you might with your friends, but strangers, which in a sense, a therapist can be seen as, it's a lot harder to talk about sex.

This quote illustrates a dialectic between formality and intimacy, which Heather reiterates about sexuality:

> It brings in discussion about perhaps the formality of the therapeutic relationship, or what words can we use? Or what? How can we talk about it in what perhaps sometimes feels like a more sort of formal and more professional space? So, if that comes up as well, it brings in the nature of the space and the premises (…) And sometimes it can feel intimate, but I think not always, not necessarily. So, I think I'd be wary of saying that sexuality is always an intimate topic.

Connected to this Carol stresses that when the space is virtual, "we get some people, I think that it's easier to talk about these things on the telephone, and that having some kind of distance and it kind of opens it up".

Space and time are closely interlinked as participants reflect on what is like to "have limited timeframes to work within" (Alexandra) and "we have a kind of negotiation about when do we start thinking about these issues" (Sam). For some, like Nanda:

> I don't feel as though I give myself to my clients, if I know the work is limited (…) even though there might have been an element of loss, but I think I probably didn't step into their world as fully as I could have.

Hence, there is an acknowledgement that "they're [clients] using that space to tell you something about, I suppose how sex is so important to them" (Sam) and therapists "often would say 'you really can say anything here this is your space'" (Heather). Carol emphasises the need for:

> Setting some boundaries around my role and how that might be a bit different to their relationship with the nurse who they can also speak to about sexual function and hormones and things like that. So, I think quite a lot of work has to go into those initial contacts with someone to explain that actually our space is going to be a bit different.

3.2.5.2 - Adapting the work to the context

Although the research question implies the existence of one therapy room, participants' clinical work varies, and they are often "negotiating different spaces in which these conversations occur" (Carol). Physical therapeutic spaces can be forensic services and physical health settings, community and impatient, private practice, and the public sector. For example, some conduct therapy in "a ward, in a hospital [where] privacy is an issue" (Carol). Anna J stresses that, working in a prison, one as "to be mindful of confidentiality, because if they're telling me they're having sex with someone, I have to disclose". Working in psychiatric impatient units often require specific ways of working:

> "Patients that I've been working with, on the wards (…) speaking about sexual violence in the past. You know, many patients were talking about that very, very openly. I feel like it's just about trying to give them privacy. (…) And, and then, of course, there have been also patients who have been also very flirtatious with members of staff, and also quite concrete, in terms of their sexual desires. (..) it's very difficult, especially (…) if it starts to feel like the client now is seeing me like a friend in some ways. And that we hopefully can now (…) share our sexual desires and speak about sex openly. Another difficulty comes into place when clients actually start to see me also as a sexual object and become flirtatious towards me or express that. Express, yeah, some feelings towards me that are more problematic. So, in both cases, I guess I'm trying to, to keep as much distance as possible. Yet also not trying to shame them" (Sabrina).

Alexandra shares a similar experience:

> Within inpatient and acute setting, I often come across patients that are mostly in crisis. And when we do see them in crisis, in acute presentation, we are encouraged particularly within the NHS to not bring up spontaneously sexual matters. There is still this idea, particularly in some types of approaches, that justify the rise of it

> spontaneously, it should come from the patient. We, we will approach it in terms of containing the patient.

For both, there is a marked difference when addressing sexuality in hospitals versus in community settings.

There are other differences, as Sam explains: “when I was working in a personality disorder service, (…) both men and women actually, there was a lot of sexual abuse or trauma that was coming on in the past”. Now working in a forensic service, “people bring up some of the things which are not considered normal, or I would consider them perverse or pathological” (Sam). Anna J emphasises that “there are lots of issues which impact that kind of work [forensic] that doesn't apply in the community in the same way”.

There is also a significant difference between working in the NHS and privately, as Heather highlights:

> People who approach me in private practice have tended to be, I guess younger. So, from 20s, 30s. So that's more of the age I get it, I think it'd be interesting, if I had worked with older clients in private practice what their narratives might be.

Lucy reflects on this difference:

> It is a less unwell client group [private]. They've got resources, because they can pay for therapy, often the people we're working with [NHS], you know, just don't have really resources to change their life, don't have supportive networks around them. Don't necessarily have the emotion regulation skills. But also, [privately] I can see them for as long as they want to be seen. Or they can go away and come back as many times as they want. They've chosen me whereas in the NHS, you’re kind of just get given someone, don't you?

Therapists adapt the work to the physical context and to the length of therapy, although sexuality seems to come up even in time-limited setups. Participants seem to “think [that it] is

about their [client's] openness" (Nanda) rather than timescales. Nanda "did a very short stint in IAPT service where I think could offer six sessions. And I'm pretty sure sex came up with one client". For Anna J working in a prison:

> (…) a lot of the work we do is short term, it is a remand prison, so they may not be staying for long. So, at assessment stage, we will look at the main presenting issue. And I would say that sexuality doesn't come up very often as an issue, as a presenting issue.

Sometimes it what is addressed and how depends on the areas of specialism. Lucy reflects on how she feels "most confident with people where there is, you know, a trauma as part of the story, or that's what's important to therapy, even if that's not the main presenting difficulty". Carol provides:

> psychological therapy to patients who are experiencing psychological problems as a result of their cancer diagnosis, or they can be carers as well. So, sexuality, in that sense, has quite a specific focus, I guess, because it's often about the impact of people's treatments and things like that, that can have an impact on people's sense of sexuality.

Although therapists stress the specificities of their work context and the influence it has in addressing sexuality, most focus on the therapeutic process, i.e., what happens between therapist and client.

3.2.5.3 - Therapeutic process: boundaries and possibilities

As seen above, it is important to give the client the opportunity to bring up sexuality without coercing them.

> Again, the first thing that comes to my mind is to, to stress that the client has control over how, how much they want to share, that I'm not going to explore, actively and that they can choose how much they want to share, though, it's also important for me to stress that it is okay, if they want to speak about it. (Sabrina)

Heather makes a similar point:

> (…) symbolically, then you don't want to get into a state of being automated and kind of (…) 'rapey', or invasive, you know, you don't want to sort of be talking about sexuality and sex. I think there isn't an awareness of the dynamic between you and them I think, especially as we're thinking about people who talk about things like abuse or sexual vulnerability or being uncertain about sexuality.

On the other side of this dynamic there is a concern "particularly in terms of that power difference, because if a therapist or counsellor does not seem open to have this conversation, or doesn't bring it in, for you, for you as a client to bring that in…" (Summer). As seen above the therapist's discomfort and lack of openness can lead to a sense of the therapist depriving the client. However, there is also an awareness that "sometimes people bring it up to avoid something else" (Sam).

Participants reflect that some areas of sexuality might be easier to address than others. For example:

> I think in terms of sex, sexual orientation, I guess. It's also quite helpful for me to clarify. I feel like that's something quite appropriate to ask in an assessment stage because it also feels like, yeah. Like this is part of socio demographics and so, so it's okay to ask that. But in terms of sexual relationships, and how intimate they are, what, how intimacy looks like. I would say oftentimes, I'm more led by the person. (Sabrina)

The dilemma then is:

> How much emphasis do we put on sexuality being an issue with the client? So, I guess what I mean by that, is we, in my previous post, we would talk a lot about the social graces, and talking about difference and talking about sexuality, and how much do we bring that to the client's attention? And one thing that was coming up for me was do we do we bring to the client's attention their heterosexual? (Nanda)

Carol is “aware that, you know, my, my friends that might not be, might be gay or might be different in some ways, it feels like it was a bigger part of their therapy experiences”.

Another important element of the process is that “in the room, and there's a gender dynamic taking place, there's lots of other dynamics generally going on” (Sam). For Lucy, ethnicity, culture and socio-economic background can elicit specific power dynamics in therapy:

> The privilege that I've had, and their view of that, which is probably well beyond what the reality actually is. Yeah, we were quite different in many ways. And although you can own it, and you can talk about it, you're still white, heterosexual female who has a job and, you know, wears clean clothes? And, yeah, it's an authority, which they're not. They don't have a choice about that.

Generally, therapists do not want “clients being concerned about offending me” (Heather). However, “there are certain things my clients are bringing that feel very close to home. And I noticed that I'm then really struggling to hold the boundary” (Heather)

The role of gender and age in the therapeutic process comes up for all participants. Anna J acknowledges that “there's a discomfort for me about talking to a man in the same way as a woman”. Carol is:

> quite aware of my own kind of characteristics, I guess, and I'm working with men that are talking about having problems to sexual function and how that might be. Most men I work with, the patients are going to be quite a lot older (…) I think you've really got to tailor it to the person that you're working with, and your understanding of them might grow your own kind of processes in this as well as you know, married heterosexual female, you know, what's [sic] what am I bringing to this?

Even if participants “try to be quite neutral” (Sam), “you have to be so self-aware. And you can't bleed out into that. And make sure it remains about the client. And perhaps the

therapeutic relationship. But it's about how do you maintain that?" (Nanda). Both participants highlight "this concept of neutrality and with that, I'm not saying that you can be completely neutral, I think that's impossible (Summer). Acknowledging that difficulty, the therapist's material can be part of the process:

> I was very much hesitant not going there, not really know enough about this stuff. And this is dangerous, don't want to put across my point of view. I don't want to come across as bigoted or I don't want to come across as overly knowledgeable when I'm not and it was, as I said I think actually she probably missed out on a lot, on, if she was with another therapist, so with me potentially at another point in time. (Mike)

Hence, most participants "don't really like general therapist disclosure (…) unless it sort of feels really therapeutic (…) I really like that boundary" (Heather) and for that "you have to put aside a lot of your own stuff" (Sam). However, complete neutrality is impossible and therapists' identities filter into the room. Lucy gives an example: "And I think the only the other times really where I've felt like my identity is fully in the room is when I've been pregnant. Mike makes a similar point about himself:

> Because of my identity, I represent in some way, because I also have a physical disability (…) but I think my own identity maybe potentially in the eyes of clients and supervisees and supervisors. I'm a therapist that works with difference.

Often the therapist is affected by the relationship insomuch they affect the relationship. For example, Nanda "did my extended case study, and I actually developed some erotic feelings towards her and I, to a point I started questioning my own sexuality". Mike and Sam remembered situations when "there might be a sexual undertone to things as well, that, I think that that's obviously something that comes to my mind, this idea of the erotic transference" (Sam). These participants point out that some transferences:

> [c]an be quite difficult to tolerate. It depends on the nature of the transference, really, because there can be some broad sized transference where it's much more about maternal and that caregiving rather than sexual and that feels easier to manage. (Nanda)

Carol highlights that sometimes the therapist material comes up in a more nuanced way, and points to self-awareness:

> And just being really mindful about our own sense of, you know, sexual beings and related sexuality and what impact that has on you know, how we address things, how well we address things, you know, what we do avoid? Because it would be okay, that would be a normal, you know, there will be some level of avoidance that we're not aware of it and I think that's quite dramatic.

3.2.5.4 – Theoretical framing

Vessel was meant in a similar to unity as described by R. Miller (2014) when introducing Vygotsky's theory of language and thinking:

> Think of a container (like a cup) that has an inside (meaning) and an outside (sound) aspect, but which can only exist as a "unity" (of both aspects) in which it is not possible to isolate the aspects from each other without destroying the whole" (p.10).

From a CHAT perspective this is a self-explanatory category. Ergo every therapeutic encounter is a relational and social space where the therapist and client's subjectivities are developed and reconstructed through a dialogical process. The relationship is the vessel in which two or more active agents interact to configure new psychological functions. Below, the main concepts used are humanist and existential because that is the conceptual framework used by participants.

Regardless of the model or psychological theory, therapists emphasise that the therapeutic alliance is essential for addressing sexuality. As Capuzzi and Stauffer (2022) suggest: "there are so many options from which to choose to guide one's practice because

theories, though different conceptually, all have one thing in common—the importance of developing a therapeutic alliance with a client" (p.3). Participants with varied approaches reinforced that empathy, congruence, and unconditional positive regard are essential conditions to address sexuality, which indicates that the person-centred model introduced by Carl Rogers (Gillies, 2010; R. Knox & Cooper, 2014; Muran & Barber, 2010) is firmly in the therapist's mind. In fact, most therapy models, similarly to CHAT, position the therapeutic relationship as a vehicle for change, an intersubjective space where subjective and social creation is possible (Gillies, 2010; Holzman, 2016; Rey, 2009; Venger & Morozova, 2014). Next, the conditions that form and operate the therapeutic encounter are discussed.

One of those conditions is "trust" which participants refer to multiple times. They build trust by showing "openness" (Heather), being "curious" (Sam and Heather), "warm, accepting, non-judgemental" (Anna J) which is shown through "open questions" (Sabrina) and "open posture" (Heather). This follows many authors, particularly Gilbert and Leahy (2007), who proposed trust as a key element of a strong therapeutic alliance even in cognitive-behavioural therapies.

Empathy is another concept that has long been discussed and accepted as a core condition for change in therapy. It was introduced by Rogers in the 1950s and has grown considerably in popularity in the field of caring and healing (R. Knox & Cooper, 2014; Muran & Barber, 2010). Hence, it is not surprising that feelings and displays of empathy are essential to addressing sexuality, even when working with perpetrators of sexual violence as Mike and Sam mention.

The idea of authenticity is associated with empathy, or perhaps, in an opposite pole. Alexandra points to the importance of clients feeling the therapist as "authentic"; however, this can be at odds with being empathic, especially in situations where the therapist might not feel comfortable with what the patient is bringing or when authenticity might demand certain acts

of self-disclosure (Elder, 2005; R. Knox & Cooper, 2014; S. Knox & Hill, 2003; Stricker, 2003). This is particularly pertinent when the theme is sexuality. Looking at how all categories of this theory connect, it is striking how therapists make a point of avoiding self-disclosure around sexuality not just in sessions but also in their own supervision and therapy therefore avoiding discomfort and limiting their opportunities of development and subjectivation, which lie at the core of authenticity. Rey (2009) from CHAT and Saketopoulou (2023) from a psychodynamic viewpoint argue that without discomfort, including the therapist's, meaningful creation is all but impossible.

Safety is another essential condition for addressing sexuality. This idea relates to another concept that has been thoroughly researched: the therapeutic frame (Cooper & McLeod, 2011; Gilbert & Leahy, 2009; R. Knox & Cooper, 2014; Muran & Barber, 2010). Therapy is a space that evokes feelings of intimacy (Carol, Nanda, Heather), yet simultaneously require a certain degree of "distance" (Carol) and "formality" (Nanda). In opposition to CHAT (Rey, 2009), participants argue that the therapeutic space is also different from other spaces which Carol illustrates by differentiating her area of work from the medical field. Anna J. and Lucy discuss the need to safeguard patients (and others) and how that role can create a space where it is not safe for the client to disclose, and privacy is not a guarantee. Some authors (e.g. Drinane et al., 2022) question the ability of therapists to fully provide a safe space when therapy outcomes are so correlated to multicultural and intersectional factors between therapist and client. An example is Anna J reflection on how she feels more comfortable discussing sexuality with women. From this perspective, this might lead to more effective outcomes with people with these characteristics which is reflected in the scant literature on the topic (see Beel et al., 2018; Berry & Lezos, 2017; Bettergarcia & Israel, 2018; Gehart & Lyle, 2001; Milton, 2017; Ritter & Terndrup, 2002; Ryden & Loewenthal, 2001).

Participants, like Nanda and Sam, mentioned that in shorter modes of therapy and certain behavioural models, they were unsure where to fit sexuality. Many authors have highlighted how the therapeutic model, context of work, and time constraints influence the therapeutic relationship and what might or might not be addressed (R. Knox & Cooper, 2014; Muran & Barber, 2010). This highlights another consideration for clinical practice, namely the need to consider issues of intersectionality and mental health (Das Nair & Butler, 2012) when considering therapist-client matching and length of therapy (Behn et al., 2018; Blow et al., 2008).

While some therapists ask about sexuality from point of assessment, in certain contexts, such as psychiatric wards, the therapist needs to keep "distance" (Sabrina) be "containing" (Alexandra). This aligns with the findings by Urry and Chur-Hansen (2020) on how staff tend to approach sexuality in psychiatric settings. This is one of the main differences in the participants' approach. Some therapists, like Sam, believe it is important to ask about sexual orientation, trauma, intimacy, and fantasies from the onset, while other participants position themselves as "led by the person" (Sabrina). This highlights a predicament around power dynamics and authority. Several authors have discussed the same dilemma in the therapeutic relationship, pointing to the inherent authority of the therapist's position (e.g. (R. Knox & Cooper, 2014). However, as Rey (2009) and Kozulin (2014) argue, power or authority are not inherent to the therapeutic encounter and institutions, but a product of historical, cultural and social construction. Simultaneously, that position of power is not intrinsically detrimental because the therapist can occupy the role of the 'competent other' (Venger & Morozova, 2014) challenging the client and fostering development, i.e. taking the lead while remaining within the client's ZDP.

Gender seems to mediate the felt sense of authority and power that participants feel they have or ought to have when addressing sexuality. All participants reflected on how they

felt more comfortable addressing sexuality with female patients (ex. Anna J) albeit striving to not be intrusive or as Heather puts it "rapey". This requires special consideration when patients might have a history of sexual trauma. Knox and Copper (2014), referring to physical touch, remark that the same gesture might be experienced very differently by the patient, depending on the therapist's gender. Gender intersects with other therapist and client characteristics, such as class, age, disability, sexual orientation, and ethnicity, as reflected by most participants. Research on the impact of these characteristics has yielded conflicting results (e.g. Behn et al. 2018). Here, CHAT is close to social constructionism, highlighting the role of social discourses, namely around power, gender and age in individual and interpersonal subjectivity (Rey, 2009).

Nevertheless, when it comes to addressing sexuality, therapists stress the importance of being aware of one's characteristics and the inferences that patients make. Therefore, participants strive to maintain distance, stay neutral, and avoid self-disclosure. These processes seem to serve two functions: one is to keep the work patient-centred and enhance the therapeutic relationship; the other function is to protect the therapist. The first function is well documented and researched (e.g. Hill et al., 2018; R. Knox & Cooper, 2014; S. Knox & Hill, 2003). What is less understood is how therapists decide on self-disclosure and the role of sexuality in those decisions with Henretty and Levitt's (2010) review of empirical literature being an exception. If we consider the opinions of participants regarding self-disclosure and boundaries in therapy, as well as their discomfort or reluctance to discuss their sexuality in supervision and personal therapy, it follows that avoiding self-disclosure serves to safeguard both the patient and the therapist.

Research suggests that feminist and LGBTIQ therapists are more likely to use and advocate for self-disclosure than heterosexual and psychoanalytic therapists (Denman, 2003; Henretty & Levitt, 2010; S. Knox & Hill, 2003) who constitute the bulk of this study

participants. That is potentially due to how those therapies tend to position themselves as challenging the status quo and fighting to change social narratives, philosophically closer to CHAT, Marxism and social constructionism (e.g. Rey, 2009). One situation in which most participants seemed to agree was the non-disclosure of the therapist's sexual feelings and the need to set clear boundaries when sexual attraction was disclosed by the patient. Although issues of sexual attraction have not been at the forefront of recent research, participants' views are supported by the literature on the topic (Gelso et al., 2014; Kapp, 1999; Lotterman, 2014) (Gelso et al., 2014; Kapp, 1999; Lotterman, 2014; Pope et al., 2006).

In summary, the therapeutic relationship is a vessel in which sexuality can be addressed which needs to be safe for both the therapist and the patient, and core conditions need to be met.

3.3 –Analysis reflective statement

Building the model was the most challenging stage of the entire research project. Charmaz (2014) suggests that "the potential strength of grounded theory lies in its analytic power to theorise how meanings, actions and social structures are constructed" (p.285). I hope I was able to harness some of this potential, albeit with several limitations.

The titles of each category and the overall model were worked on and reworked until I arrived at this version which was only final because of the submission deadlines. What I mean is that the model is possible within time constraints. I do not claim to be "a first explorer on distant shores" (Charmaz 2014, p.289) but believe that at least I was able to expand on current knowledge about sexuality in therapy.

Retrospectively, I can see how influenced I was by my previous readings and work with cultural-historical psychology. For example, the idea of frontier partially germinated from the translation of chapter 6 of The Cambridge Handbook of Cultural-Historical Psychology:

Encountering the Border (Valsiner & van der Veer, 2014) back in 2016. As previously alluded to, I was an active member of a group of psychologists that studied the works of Lev Vygotsky, A.N. Leontiev and Alexander Luria extensively between 2008 and 2013, reading and applying many of their ideas to clinical practice with both children and adults. Unfortunately, CHAT is not very popular in the UK or counselling psychology and so much of that learning stayed latent, resurfacing again in this theory. In hindsight, the choice of methodology was heavily influenced by my experience with CHAT too. Charmaz suggests that CGT researchers often have a particular vantage point when setting on a project and one of those is Marxism (Bryant & Charmaz, 2019), coincidently also the starting point of CHAT. My intention was always to capture data reflecting the cultural, social and historical context in which therapists live and work and the intra and interpersonal processes involved in addressing sexuality.

CGT coding in gerunds aims to capture the importance of action and CHAT positions culture and activity as central to human development.

While constructing the theory, some ideas had to be prioritised over others. One example is the idea of "negotiating dilemmas", one of the first memos I wrote. Although this concept is encapsulated in other ideas such as "limits and possibilities" and "negotiating permission", it does not feature as a category, central as it was to most of the theory construction.

Other avenues that I wished I explored further include the paradox of therapists grappling with addressing clients' sexuality while simultaneously refraining from exploring their own in the context of supervision and personal therapy. Another was the impact that self-awareness of gender, sexual orientation, and age might have in how therapists address sexuality.

I began developing my initial model approximately one year prior to submitting my thesis. Throughout the process of writing this section, reviewing literature, composing the

discussion, and drafting the article, the theory underwent continuous refinements, becoming increasingly theoretical and analytical. Inherent to this process was the idea of dialectics as seen in Appendix 10 and thought of by Vygotsky (1982b, 1982a).

I tried to follow Charmaz instructions closely but there is so much left to the individual researcher's construction that undoubtedly this is a model idiosyncratic to me, with all its strengths and weaknesses.

Hopefully, the next chapter will further strengthen the model by giving it a theoretical framework.

Chapter 4 – Discussion

This chapter critically examines the grounded model from a perspective of cultural-historical activity theory, simultaneously situating the grounded theory within the broader field of sexuality and psychological therapy.

The section includes limitations of this study and grounded theory, suggestions for future research and clinical and training implications with a special focus on CoP.

This chapter concludes with a reflection on the whole research process, mainly focusing on the impact on the researcher's development and clinical practice.

4.1 – Brief review of the model

The review of the model draws upon current literature to further extricate and saturate the theory of navigating on the frontier of sexuality. As seen during the theoretical framing of each category, CHAT is the main conceptual framework used but alongside psychodynamic and existential ideas. In the title, frontier is thought of as "while fitting the role of the border (exemplified as central in mereotopology) it represents a constantly moving, dynamic border

in the direction that is teleological in irreversible time" (Valsiner and Veer in Yasnitsky et al., 2014, p.169). Therefore, this is a contextual, imagined border that is different depending on who perceives it and when. It is a space but also a time that has not been actualised yet, remaining a possibility. It is this space-time between the sexuality that is and what can become that therapists work in a collaborative dialogical process.

The therapist is at the centre of the model because the exploration of sexuality starts with their own. Their ontogenetic experiences of sexuality work like a subjective navigation map, informing therapists' feelings, thoughts and behaviours in therapy. In summary, therapists feel the need to question and overcome sexual narratives they grew up and navigate their discomfort, gaining confidence through clinical practice.

However, sexuality remains an explored area in training, supervision and personal therapy which reduces the opportunities to "play" with sexual themes and use of "the competent other" to develop new forms of thinking sexuality.

When meeting the client, the therapist's subjectivity meets the clients' and both co-construct individual meanings using the available language and social discourses as tools to make sense of sexuality.

This process is only possible because the therapeutic relationship works as a vessel or container made of clear boundaries and constituting a safe interpersonal space that forms and informs subjectivation of sexuality.

4.2 - Implications for training and clinical practice

In their 2022 article, Debra Mollen and Dena M. Abbot start the abstract with: "Sexual health and sexual well-being are vital components of overall physical and mental well-being, yet remain largely understudied, approached mainly from disease prevention and intervention perspectives, and generally excluded from most health service psychology training

programs" (p.280). The authors capture how sexuality is generally approached in clinical practice, training, and research. This section discusses the implications of the grounded theory model for these three areas, starting with training.

4.2.1 – Training

As seen above, participants overwhelmingly reflected on the lack of training around sexuality in general and the specificities of addressing it in therapy. Therapists need to compensate for lack of training which raises important issues and opportunities for improvement. As indicated above, many researchers (Abbott et al., 2022; Burnes et al., 2017a; Carrington & Sims, 2023; Mollen et al., 2020; Mollen & Abbott, 2022; Ridley, 2006; Shaw et al., 2008) suggest that despite an improvement in training in sexuality, there is still a need for academic institutions to expand on the duration, quality, consistency and breath of training. Even in the specialist field of sex therapy this seems to be the case (see Nasserzadeh, 2009), indicating that there is an even bigger gap in the provision of training and quality psychosexual therapy for GDSR and LGBTIQ populations (Berry & Lezos, 2017; Neal & Davies, 2000; Neves et al., 2023d; Peterson, 2017; Ridley, 2006).

The lack of training and the consequent lack of comfort and competency in addressing sexuality due to a lack of appropriate training, including continuing professional development is an issue for mental health clinicians across borders and mental health professions (see Dyer & Das Nair, 2013; Higgins et al., 2008; Saunamäki et al., 2010; Urry & Chur-Hansen, 2020; Wendt et al., 2011; Yallop & Fitzgerald, 1997; Young et al., 2020; Zamboni & Zaid, 2017). Therapists having to rely on their clinical experience and personal interests raise doubts about an adequate and effective approach to sexuality across mental health courses and professionals. This is especially relevant when there are such varied training routes for becoming a mental

health clinician (Canvin et al., 2023; Giami & Pacey, 2006) and such diversity of relationships, sexual orientation, behaviour and gender (Neves, 2021, 2023; Neves et al., 2023b, 2023b).

The BPS and BACP developed guidelines for training psychologists, psychotherapists, and counsellors in sexual health (D. M.-J. Barker, 2017; *Guidelines for Psychologists Working with Gender, Sexuality and Relationship Diversity*, 2019; Shaw et al., 2012). These guidelines emphasise important competencies, such as being aware of the diverse forms of human sexuality and reflecting on attitudes or emotions that may be elicited. In the participants' experiences, this training is seldom made available. This is especially concerning for non-normative sexual and relationship expressions (Bieschke et al., 2014; S. J. Ellis et al., 2019; Montenegro, 2015; Schechinger et al., 2018). Consistent with the idea of moving through uncharted territory, the quality and quantity of training, as well as the areas addressed, are left to the individual institutions, lecturers, and trainers. Professional bodies could make training and CPD on sexuality more frequent, consistent, and accessible, or at least provide clear guidelines for training in sexuality across mental health professions, specifically in psychology, psychotherapy, and counselling.

A final thought on training is sex positivity, affirmative practice and LGBTIQ psychology. Despite the wealth of articles and books published in recent years and the hopes of authors like S. J. Ellis et al. (2019) learning about sexuality remains largely self-directed, hence risking perpetuating sex-negative, heteronormative, cisgender, and monogamic views.

CHAT can offer a useful training framework having extensively been used in education (e.g. Daniels et al., 2007; Holzman, 2016). The emphasis on cooperative activity, mediation through available social tools, play and creation could help practitioners develop confidence to address sexualities.

4.2.2 - Clinical practice

The idea of navigating the frontier is perhaps the most useful for clinical practice for different reasons. Frontier is meant to both signify what Saketopoulou (2014, 2023) calls limit experience and limit consent but also the idea of zone and border as described in CHAT (del Río & Álvarez, 2007; Yasnitsky et al., 2014) being a space between what is known and what could be developed and that often requires a reconfiguration of existing psychological functions.

Still according to CHAT and the model developed, learning precedes development which means that institutions and GSRD competent professionals have an important role to play in creating and sharing the tools for other therapists to use and develop.

Ethical clinical guidelines across professional bodies highlight therapists' responsibility to stay informed and adequately trained (Butler et al., 2009; Shaw et al., 2012). However, as seen in the section above, participants are working on the frontier, relying on their personal resources to manage. As much as the onus is on therapists to stay updated, it is also important that institutions such as employers and professional bodies provide the necessary opportunities, especially when research suggests that "issues of sexuality are not frequently addressed in the healthcare system" (Dyer & Das Nair, 2013). This reinforces and maintains professionals' perceived lack of comfort, confidence, and competence in addressing sexuality. Hence the idea of permanently having to navigate a plethora of different processes and issues without feeling adequately prepared to do so.

Some of the values of counselling psychology, such as pluralism, existentialism, humanism, and reflexivity (see Murphy, 2017; Strawbridge et al., 2016) could be useful to inform practice across mental health professions. Like participants highlighted, it is essential that one acknowledges one's feelings about different areas of sexuality and deals with them. Otherwise, they may incur the risk of neglecting clients' needs and further shame clients in an

area of life already seen as taboo (M. L. Ellis, 1997; Love & Farber, 2017). This grounded theory offers clues on how those values can be used both in clinical practice and training. For example, positing individual diversity (pluralism) as a strength when therapists are willing to challenge their own subjective construction of sexuality (reflexivity) in the therapeutic space, thus co-constructing meaning (humanism) in a dialogical process that uses whatever cultural-historical tools (e.g. language) available.

Some participants reflected on how their own experience of supervision and personal therapy influenced how confident they were in addressing sexuality in their practice. Including sexuality in supervisor training could help bridge the gap between good practice and therapists' self-perceived confidence. Clinical supervisors also need to be aware of their responsibilities in modelling and approaching sexuality with confidence, openness, and care (Bieschke et al., 2014; Carrington & Sims, 2023; Chui et al., 2018; Farber, 2003; O'Donovan et al., 2011). Equally, therapists could be prompted to discuss their sexuality in personal therapy as part of their clinical development and reflect on what might the barriers be.

The model often identified participants as working on the frontier of knowledge about sexuality, their own, and their profession. Again, values around inclusion and social justice might help balance the idea that there is no room for sex and sexuality in therapy, especially in certain settings where medical and diagnostic-specific practices might prevail. Stetsenko and Arievitch (2004) explain the project initiated by Vygotsky and developed by several authors during over 100 years as "aimed at constructing a practice-oriented psychology suited to solve real-life problems within the overall quest for a humane and just society" (p.481). This is the very definition of CoP and its ideas of research-practitioner, reflective practitioner, pluralism and social justice (Murphy, 2017; Strawbridge et al., 2016).

4.2.3 - Suggestions for future research

This study contributes to advancing research on sexuality from the perspective of counselling psychology. Although counselling psychologists have made important contributions to research on LGBTQI topics, sexuality research has been limited in the field of CoP (Hargons et al., 2017). This seems at odds with counselling psychologists' identity as scientist-practitioners (Strawbridge et al., 2016).

After a revision of the literature on research on sexuality and counselling psychology, it seems that findings by Hargons et al. (2017) are still valid, as most research on sexuality coming from CoP tends to be quantitative. More qualitative studies, such as this one, from a constructivist stance with a focus on narratives and processes involved in discussing sexuality are urgently needed in psychology, psychotherapy, and counselling.

As reflected in the literature review, research on sexuality and mental health is not as common as expected, and it would be useful to know more about how different professionals address sexuality. Especially in an era of multidisciplinary work, it would be helpful to examine best practices across different professions and how CoP might inform and learn from them. It would also be helpful to understand how mental and sexual health intersect and further learn how different professionals address it.

Another suggestion for research relates to how much supervisors are trained and asked to address sexuality with their supervisees and the impact that the supervision processes might have on therapists' development and practice. This is particularly true for issues related to safety, trust, and self-disclosure. The categories and themes created in this grounded theory could be operationalised to capture the experiences of more therapists and clients and be used to inform the best clinical practice.

Other themes that need further exploration are dialectics in the therapeutic space, conceptualising sexuality among other areas of life, and processes contributing to personal

interest in sexuality. It would also be useful to know how therapists address sexuality with children and younger people, older adults, people with physical disabilities, and other populations not captured in this study.

Finally, more research is needed about a pluralistic or integrative approach to address sexuality in therapy. This grounded theory, with its CHAT framework, could offer a springboard for such research. For example, ZDP integrates ideas related to sociogenesis, relationships, dialogue, co-creation, mediation, and scaffolding (del Río & Álvarez, 2007). All ideas and strategies mentioned by participants that could be formally researched in the context of approaching sexuality in therapy.

Despite an increase in sex-affirmative research in recent years, there are still substantial gaps in the literature, and as S. J. Ellis et al. (2019) note, research is still often permeated by cisgender, heteronormative, monogamic ideas. Further research in these areas as well as intersectionality and multiculturalism could have wider implications for policymaking and the establishment of more consistent practices across services and professions, with benefits for the wider public.

4.3 - Limitations of the study

One of the main limitations of this study is that it was designed specifically with counselling psychologists in mind and then changed to include other psychology, psychotherapy, and counselling professionals. Although the expansion of recruitment bodes well with the grounded theory principle of heterogeneity, the literature review and interview schedule may not fully capture the variety of professional backgrounds and identities. This also means that the theory developed in this study could and should be enhanced with more cultural, relational, and sexual diversity of participants, as well as professional backgrounds.

The duration of the project also offered advantages and limitations. The initial proposal was made in 2019. Since then, many studies on sexuality, psychotherapy, and psychology have been published and not included in the literature review and discussion.

The protracted recruitment and data collection led to less time for the analysis. Charmaz (2014) acknowledges that academic time constraints can impact how thorough, innovative, and saturated a new theory is. This was a concern during the development of this study.

Another point to reflect on relates to the difficulties in recruitment. The ten participants agreed to take part because they found the topic interesting, which begs the question of how other therapists who do not find the topic interesting or relevant may be approaching sexuality. Bredal et al. (2022) identified three main reasons for victims of interpersonal violence to participate in research: wanting to share their story, wanting to contribute to change and simply wanting to help the researcher. This study's participants indicated similar motivations. Some therapists contacted directly declined to participate because sexuality was not part of their work. In retrospect, it would have been helpful for the purposes of theoretical sampling to have interviewed those therapists.

Initially, the plan was to recruit participants in the Greater London area, acknowledging how densely populated, diverse, and liberal the area is compared to other parts of the UK and other countries. The recruitment was then extended to all the UK and Northern Ireland; however, all participants ended up working and/or residing in Greater London. The grounded theory is London-centric with the caveat that research from other countries seems to support the grounded theory model more widely.

Another possible limitation is that the study was conducted individually which raises questions regarding the validity and reliability of the model. Although this is not the aim of constructivist grounded theory (Charmaz, 2014), the plausibility and adequacy of the categories can and should be questioned.

Finally, an attempt was made to mitigate the risk of perpetuating cisgender, heteronormative, and monogamic views and practices through the researcher's critical reflection on every part of this study, but most participants were female, cisgender, and heterosexual, as is the researcher.

4.4 - Final reflective statement

This project was professional and personal in equal measure. As mentioned in the first reflective statement, my interest was born partially from a place of trauma. It was a challenging process but a healing one. The protraction in submitting the thesis was partly because of how challenging the topic often felt. Other two important factors were physical health issues and changes to supervision. However, in retrospect, I believe that overcoming those challenges has allowed me to explore different areas of sexuality that I had not considered initially. Choosing constructivist grounded theory allowed me to incorporate my own process into the construction of the model. I am unsure whether I would have been able to effectively separate my assumptions, attitudes, values, and beliefs from the constructed model.

Although, I was clearly heavily influenced by my previous experience of CHAT, the theory was barely mentioned in the first submission of the thesis. From the choice of topic to data collection and analysis and theory development, CHAT was at work. However, I was working under a rigid understanding, that such theories, being rarely if ever associated with CoP, would not be accepted in a quality research project. I am grateful for being allowed to make its influence explicit and make sense of addressing sexuality through that lens.

The choice of addressing versus approaching was a personal one and based on CHAT. I chose 'addressing sexuality' because it implies actively acknowledging and taking steps to resolve or explore a specific matter. It requires proactive and intentional effort to directly engage with the subject at hand and provide appropriate responses or actions. Approaching

refers to the initial stages of encountering or considering a subject, without necessarily indicating active problem-solving or resolution. This choice was clearly based on my assumption that sexuality is something that needs addressing; however, Nanda and Mike insightfully asked, “does sexuality always have to be addressed?”. Now reflecting, perhaps addressing has a hint of heteronormativity to it, as if sexuality is something to be fixed, which I did not consider initially. However, addressing implies active engagement with and I believe that if the research question had not been framed like that the idea of navigation would not have been developed.

By conducting this study, I developed as a practitioner, but always held in the back of my mind, a concern about its relevance for CoP. I feel reassured by my supervisor’s encouragement and Charmaz’s view that grounded theory can simply bring a new perspective into old ideas (Charmaz, 2014). Given the opportunity, I would have liked to have focused more on sexual and relational wellbeing and be able to contribute to the development of a coherent, positive, and affirmative approach to sexuality. Nonetheless, this theory aligns very closely with CoP values and CHAT offers a very useful framework in which CoP can make sense of sexuality and its own identity.

I could have explored other paths, developed other maps, or selected other tools and concepts. I would have liked the opportunity to further expand and investigate ideas that were left unexplored because of academic restrictions. I believe that CHAT reframing adds value to this theory, however, given time I would have liked to explore concepts such as perezhivanie (roughly translated as experiencing) and differences between meaning and sense making and subjectivity. However, constructing grounded theory is a personal process of permanent choice and change and this one is the construction possible in this context.

Chapter 5 – Conclusion

I set up to explore how therapists address sexuality in therapy. This project emerged from my personal curiosity about sexuality, which was not really addressed in my own therapy sessions. The initial literature review revealed that sexuality is generally considered an important part of human experience but conspicuously absent from therapy (Butler et al., 2009; Mosher, 2017; Weeks, 2017). Qualitative studies mostly focus on the client's perspective, which is crucial but lacks insight into therapist experiences. I hope that this study has contributed to bridging that gap.

It was enlightening to discover that, like myself, therapists' personal experiences play a significant role in how they approach sexuality and how they grapple to integrate their diverse feelings about sexuality into their practice. Clinical experience is crucial for developing confidence and comfort. Personal landscape mapped; therapists enter uncharted territories. Personal and clinical experiences only take them so far; the rest of the way should be enabled by training. However, most participants had deficient or inadequate training which they compensate for by relying on role models and self-directed study. Biology, culture, society, history, religion, and politics all contribute to different, sometimes contradictory, maps of sexuality which can have many meanings and expressions. What is common among participants is the belief that sexuality is inherent to human experience.

The processes highlighted above filter into therapy, carried out by both therapists and clients. Therapists address sexuality by co-creating shared meanings using the available language. Language is the tool that allows the individualisation of social narratives and the overcoming of shame. The other process in the room is the therapeutic relationship which works as a vessel in which sexuality is addressed. The vessel needs to be safe, trustworthy, flexible, and adaptable to the context. This provides a world of possibilities within boundaries.

Memos on navigation were developed quite early in the analysis. So did the idea of unexplored territory. In my view, navigating the frontier encapsulates all the ideas mentioned above and captures how therapists address sexuality in therapy.

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Appendices

Appendix 1 – advert

Call for participants!

I am a third-year counselling psychology trainee at London Metropolitan University, seeking research participants.

This is a grounded theory of how counselling psychologists approach sexuality in therapy.
The participation criteria are:
*to be a qualified counselling psychologist (HCPC registered and/or BPS accredited).
*in a clinical patient facing role

Participation involves one interview of around 1h, online, which would be recorded.

If you would like to take part, please contact me on 07*******9 or email

.

You can also support this research project by disseminating this advert.

Thank you.

Appendix 2 – Information sheet

Participant information sheet

I am a trainee counselling psychologist at London Metropolitan University and am currently carrying out research on how psychotherapists address sexuality in therapy.

Sexuality has been historically considered an integral part of the human experience; however, literature suggests that it might be a neglected or avoided topic. Psychotherapy and Counselling professions have largely contributed to the body of research on sexuality, but most studies focus specifically on gender and sexual orientation, providing only a partial understanding of what might be the practices and relevant processes.

By constructing a grounded theory of how therapists approach sexuality in therapy, I hope to contribute towards the body of knowledge, improving therapists and clients experience of therapy when addressing sexuality.

I am contacting you in the hope that you will be interested in helping me in this endeavour and share your experience.

You must:

- practice in the UK
- be a Counselling Psychologist, Clinical Psychologist, Counsellor or Psychotherapist (HCPC registered and/or BPS, BACP, UKCP or BABCP chartered/registered).
- actively working in a clinical role (must not be retired, only offering supervision or in managerial positions with no client contact),

If you agree, we will do an interview which will last approximately 60 minutes and will be voice/online recorded. Interviews are strictly confidential. All recordings will be kept securely and destroyed once the project is completed. Your name and any identifying information will not be used in the study. Data from your interview will be used for my Doctoral level counselling psychology project and it might be shared with my supervisor. Please note that my director of studies or the external examiner may request access to the raw data for verification purposes, in which case all identifying information will still be removed.

You may find that talking in depth about sexuality and your professional practice can be an emotional and potentially challenging experience. If you find any of the interview questions difficult or intrusive you do not have to answer them, and there will be no pressure put upon you.

If you do decide to take part, you will be asked to sign a consent form. You are free to withdraw this consent within 2 weeks of the interview without giving a reason. The consent forms will be kept separately and will only serve to verify that proper consent has been obtained.

Upon completion, the thesis will be stored and available in the University Library and I intend to submit the completed study for publication with a renowned journal. Successful publication would require me to retain all data for a certain length of time. This could be around five years, depending on the journal. All interviewees are invited to request a copy of the final study after completion of the project, in September 2023.

This study has been approved by the Research Ethics Review Panel at London Metropolitan University and will be conducted in accordance with the ethical guidelines provided by the British Psychological Society and The Health and Care Professions Council.

If you have any questions, comments or complaints about this study please get in touch with me, either in person, via phone or email. Alternatively, you can contact my director of studies: Dr Catherine Athanasiadou–Lewis by email: Cathanasiadoulewis@londonmet.ac.uk or on 020 7133 2669.

If you are interested in taking part in this study, please contact me either in person, via phone or email.

Monica Videira
07857 7707 879
mov0051@my.londonmet.ac.uk

Appendix 3 – Consent Form

LONDON METROPOLITAN UNIVERSITY

Consent form

Title of research: A grounded theory of how psychological therapists address sexuality in therapy.

Description of procedure: In this research you will be asked a few questions about your experience of addressing sexuality in therapy. The interview will be online and take around 60 minutes.

I understand the procedures to be used.

- I understand I am free to withdraw from this study without questions. However, data analysis will start within 2 weeks of this interview and will be aggregated by end of 02/2023 therefore, if I wish to withdraw, I will do so within the next 2 weeks of the interview.
- I understand that participation in this study is anonymous. My name will not be used in connection with the results in any way, a pseudonym will be used on the digital voice recording and all information that may otherwise identify me (e.g. local of practice or service) will be changed prior to transcription.
- There are limits to confidentiality and it will be breached if any information is disclosed that indicates a risk to my safety or others. This includes sharing of information under BPS and HCPC whistleblowing guidelines.
- I understand that the results of the study will be accessible to others when completed and that excerpts from my interview (minus identifying information) may be used within the study.
- I understand that I may find this interview upsetting and that it may evoke difficult and distressing feelings for me. I will be offered support and the opportunity to discuss these feelings post interview with the researcher. The researcher will also give information on further support available if required.
- I understand that I have the right to obtain information about the findings of the study and details of how to obtain this information will be given in the debriefing form.
- I understand that the data will be destroyed once the study has been assessed, unless published which might require data to be kept for up to 5 years.

Signature of participant:	Signature of researcher: 
Print name:	Print name: Monica Videira
Date:	Date: 16/01/2023

Appendix 4 – Interview schedule

Interview Schedule

Main questions

- How do you address sexuality in therapy?
- What is that like?
- What factors might influence you?
- How does that affect you and your clients?
- What do you think/ feel/do when a client brings sexuality up in therapy? Why do you think might be their motivation/reasoning?

Other possible questions

- What does sexuality mean to you?
- What role do you think it plays in human experience and therapy?
- What factors might be contributing to how you address and feel about approaching sexuality in therapy?
    - Personal experiences?
    - Culture?
    - Training?
    - Practice setting?
    - Therapeutic model?
- In you your practice, do you elicit/avoid the topic?
    - How do you bring it up?
    - What happens next?
- Do your clients elicit/avoid the topic? How do they do that?
    - Why might that be? What factors might play a role?
- After reflecting on your experience of addressing sexuality in therapy, is there something else you would like to add?
- Is there something you would like to ask me?
- How was this interview for you?

Appendix 5 – Interview schedule modified

Interview Schedule

Main questions

- How do you address sexuality in therapy?
- What is that like? What do you think/ feel/do.
- What factors might influence how you address sexuality?
- Is trauma something that you consider?
- Where does your understanding of sexuality come from? Does your model or context of work influence you?
- Why do you think you address sexuality in the way that you do? What factors might play a role? What might be the internal and external processes?
- What do you think of the ideas of permission, avoidance and the client hinting at sexual content?
- Have you ever dealt with sexual attraction? Yours or the client? How did you deal with it?
- After reflecting on your experience of addressing sexuality in therapy, is there something else you would like to add?
- Is there something you would like to ask me?
- How was this interview for you?

Appendix 6 – Ethical approval

Declaration

I confirm that I have read London Met's *Research Ethics Policy and Procedures* and *Code of Good Research Practice* and have consulted relevant guidance on ethics in research.

	Name	Signature	Date
Student	**Monica Videira**		**25/02/21**
Supervisor	**Dr Catherine Athanasiadou-Lewis 23/2/20**		
Principal Investigator			

PSYCHOLOGY: REVIEW

Reviewer

Enter **X** in correspondence with one and only one of the following statements:

C	Clear without amendment.	**x**
M	Clear conditional on the requested changes being made (minor modifications).[1]	
R	Revise and resubmit (major modifications).[2]	

Comments (required for M and R referrals).

	Name	Signature	Date
Referee	**Dr Raffaello Antonino**		**18/03/21**

Final judge (if one was appointed)

Enter **X** in correspondence with one and only one of the following statements:

C	Clear without amendment.	
M	Clear conditional on the requested changes being made (minor modifications).[3]	

[1] The project must be revised. The revised project has to be approved by the supervisor **only**. The revised project, signed by both student and supervisor, must be submitted, for auditing purpose, via the **Minor Modifications Archive** submission link.

[2] The project must be revised, signed by both student and supervisor, and resubmitted via the ordinary submission link as if it were a new submission.

R Revise and resubmit (major modifications).[4]	

Comments (required for M and R referrals).

	Name	**Signature**	**Date**
Final judge			

Feedback from Ethics Review Panel

	Approved	***Feedback where further work required***
Section A	Yes	
Section B	Yes	
Section C	Yes	
Date of approval		23/3/21
NB: The Researcher should be notified of decision within <u>two</u> weeks of the submission of the application. A copy should be sent to the Research and Postgraduate Office.		
Signature of RERP chair		M.B. Wheeler

Appendix 7 – Debrief Sheet

Debrief sheet

Dear XXXX,

Thank you for participating in this research study. Your contribution and time are greatly appreciated. I would like to remind you that your data will be stored securely, and any information that you have given that will be included in my thesis, and any resultant publications, will be anonymised. This means that your name and any identifying information will be removed.

I would like to remind you that you are free to withdraw from the study at any point, however, I would urge you to do it within 2 weeks of this contact, before I start processing the data.

If you would like to speak to someone further about any of the issues that arose, and/ or if you feel distressed by any of the topics discussed, I have provided some information about support services at the bottom of this page. I would also advise you to discuss any issues (ethical and otherwise) with me and my supervisor – details below.

Monica Videira
Email: mov0051@my.londonmet.ac.uk
Phone: 07857707879

Supervisor:
Dr Catherine Athanasiadou -Lewis
E-mail: c.athanasiadoulewis@londonmet.ac.uk
Phone: 020 7133 2669

If you think that any distress or issues arising from your participation in this study may impact on your professional practice, please discuss with your supervisor and contact your professional body (e.g., BPS, HCPC) for further guidance and support.

LONDON METROPOLITAN UNIVERSITY

As mentioned before, you can request a copy of the completed study. This will be available in September 2023. Please indicate your interest at the time of the interview or email me on the above address.

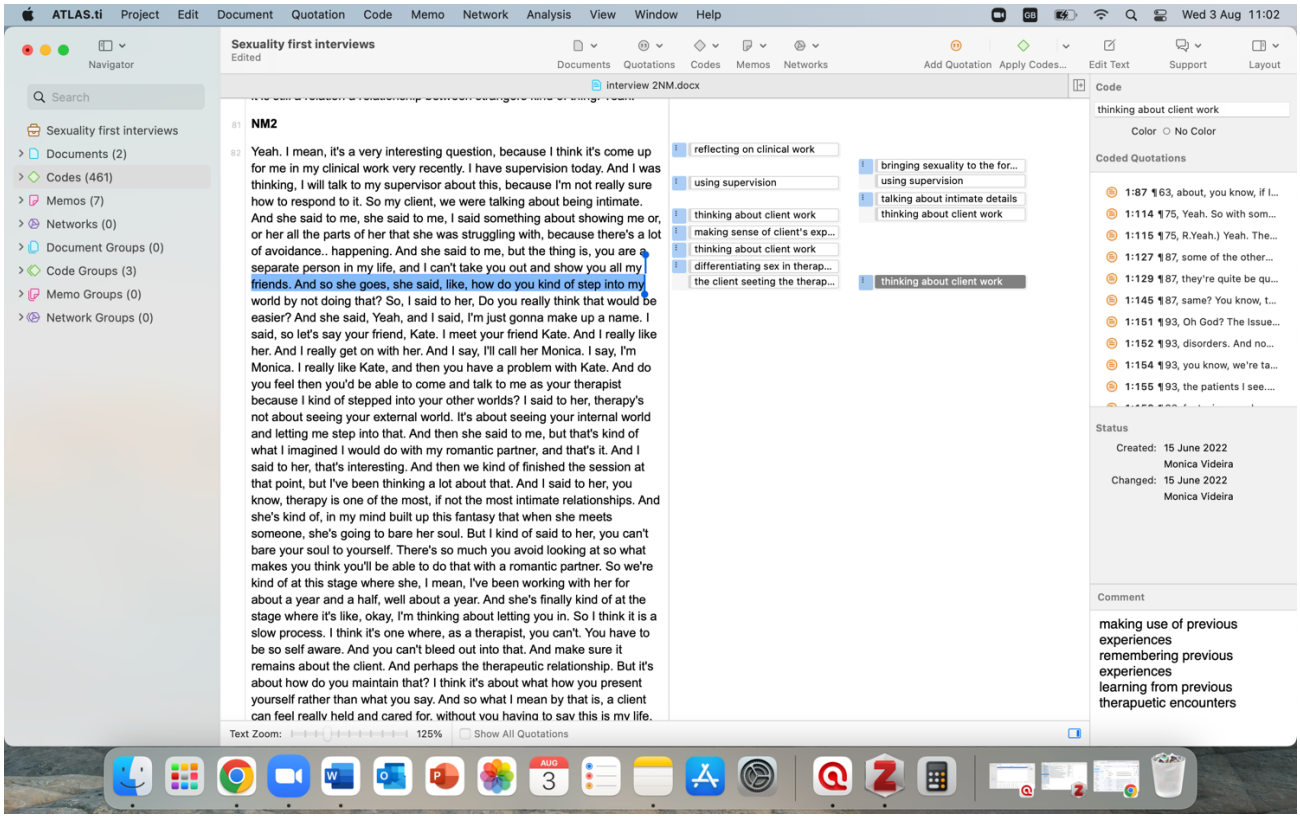
Support Services:
Samaritans
Website: https://www.samaritans.org
Tel: 116 123 (freephone)
Email: jo@samaritans.org

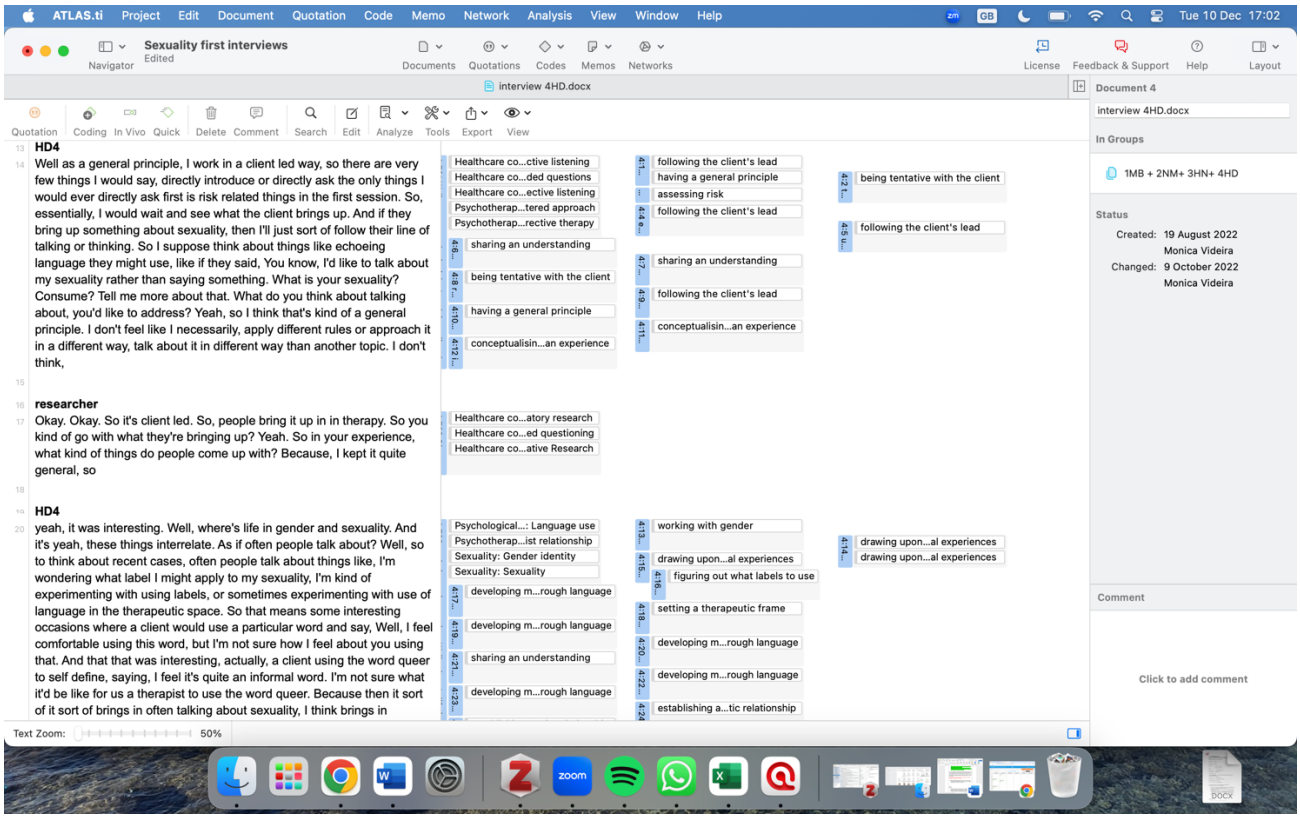
Rethink Mental Illness Advice Line
Website: http://www.rethink.org/about-us/our-mental-health-advice
Telephone: 0300 5000 927 (9.30am - 4pm Monday to Friday)
Email: online contact form

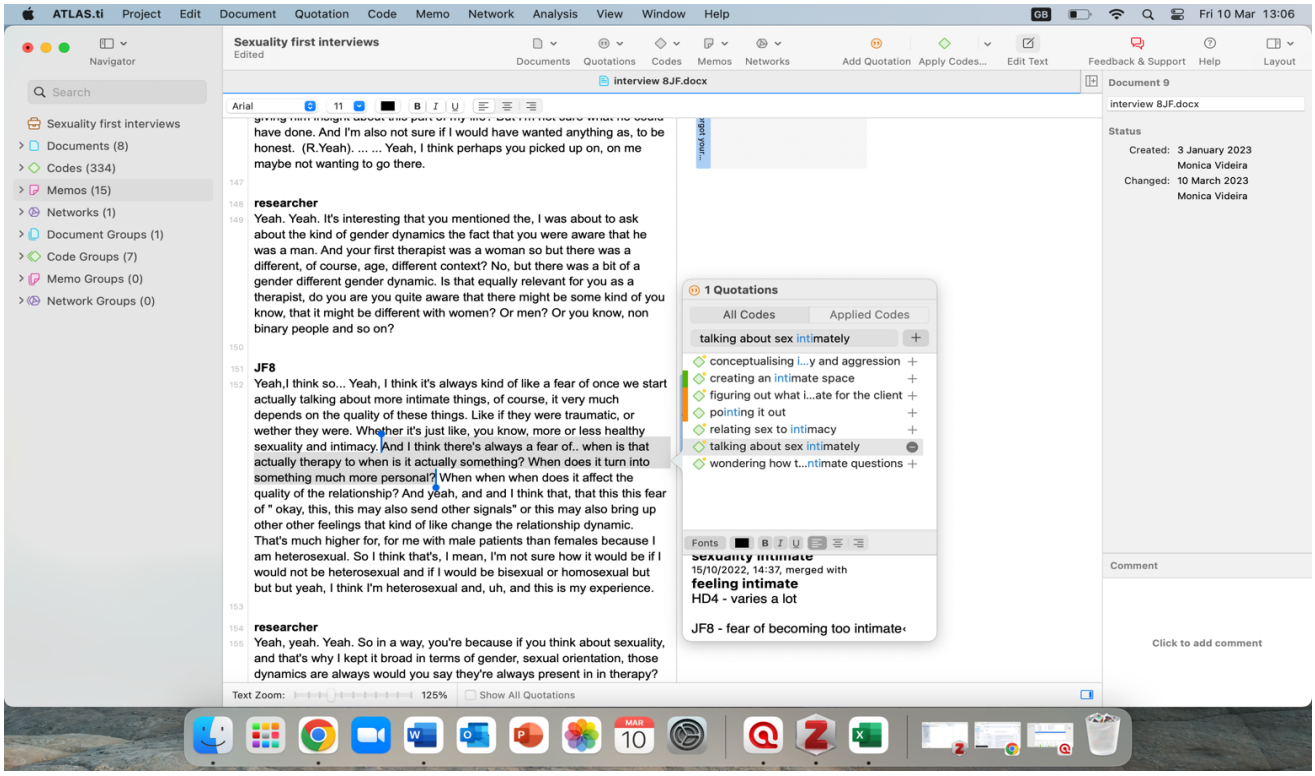
Mind
Website: www.mind.org.uk,
Tel: 0300 123 3393 (9am-6pm Monday to Friday) or text 86463
Email: info@mind.org.uk

Thanks again,
Monica Videira

Appendix 8 – Initial coding



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have done. And I'm also not sure if I would have wanted anything as, to be honest. (R.Yeah). ... ... Yeah, I think perhaps you picked up on, on me maybe not wanting to go there.
researcher
Yeah. Yeah. It's interesting that you mentioned the, I was about to ask about the kind of gender dynamics the fact that you were aware that he was a man. And your first therapist was a woman so but there was a different, of course, age, different context? No, but there was a bit of a gender different gender dynamic. Is that equally relevant for you as a therapist, do you are you quite aware that there might be some kind of you know, that it might be different with women? Or men? Or you know, non binary people and so on?
JF8
Yeah,I think so... Yeah, I think it's always kind of like a fear of once we start actually talking about more intimate things, of course, it very much depends on the quality of these things. Like if they were traumatic, or wether they were. Whether it's just like, you know, more or less healthy sexuality and intimacy. And I think there's always a fear of.. when is that actually therapy to when is it actually something? When does it turn into something much more personal? When when when does it affect the quality of the relationship? And yeah, and and I think that, that this this fear of " okay, this, this may also send other signals" or this may also bring up other other feelings that kind of like change the relationship dynamic. That's much higher for, for me with male patients than females because I am heterosexual. So I think that's, I mean, I'm not sure how it would be if I would not be heterosexual and if I would be bisexual or homosexual but but but yeah, I think I'm heterosexual and, uh, and this is my experience.
researcher
Yeah, yeah. Yeah. So in a way, you're because if you think about sexuality, and that's why I kept it broad in terms of gender, sexual orientation, those dynamics are always would you say they're always present in in therapy?
1 Quotations
All Codes Applied Codes
talking about sex intimately
conceptualising i...y and aggression
creating an intimate space
figuring out what i...ate for the client
pointing it out
relating sex to intimacy
talking about sex intimately
wondering how t...ntimate questions
Fonts
15/10/2022, 14:37, merged with
feeling intimate
HD4 - varies a lot
JF8 - fear of becoming too intimate
Text Zoom: 125% Show All Quotations
Document 9
interview 8JF.docx
Status
Created: 3 January 2023 Monica Videira
Changed: 10 March 2023 Monica Videira
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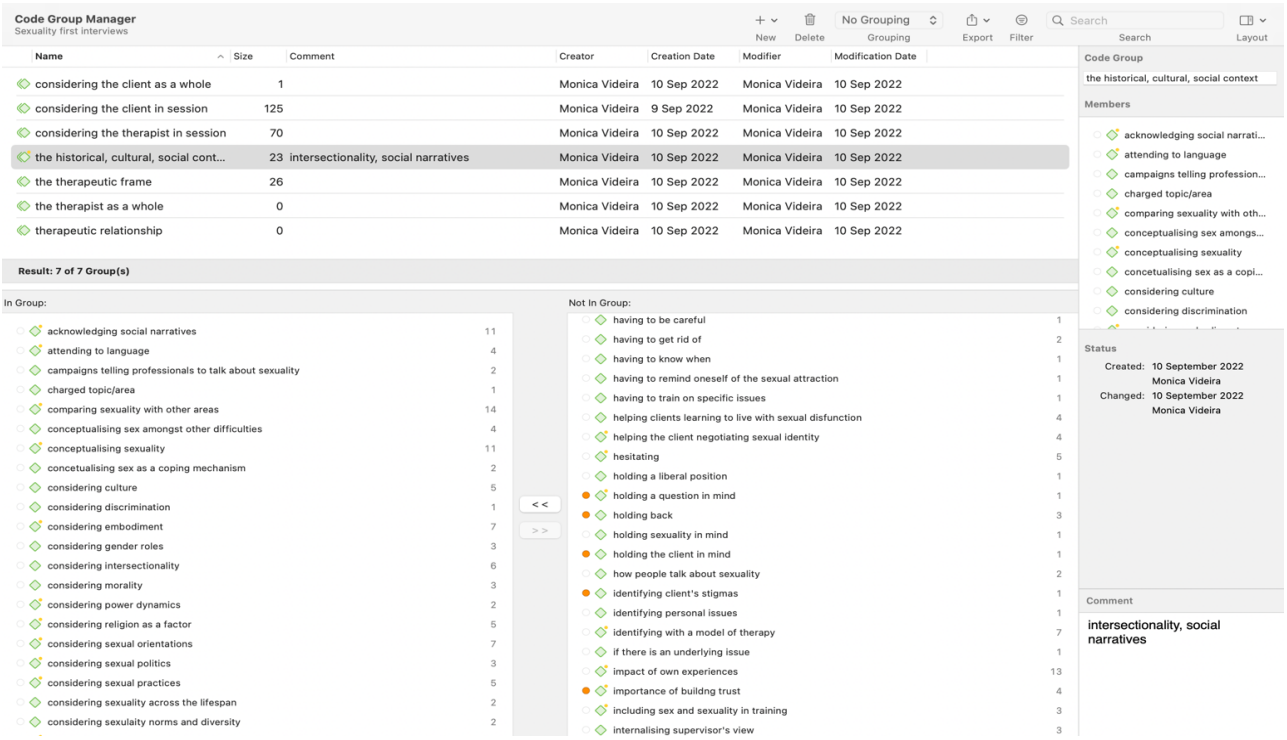
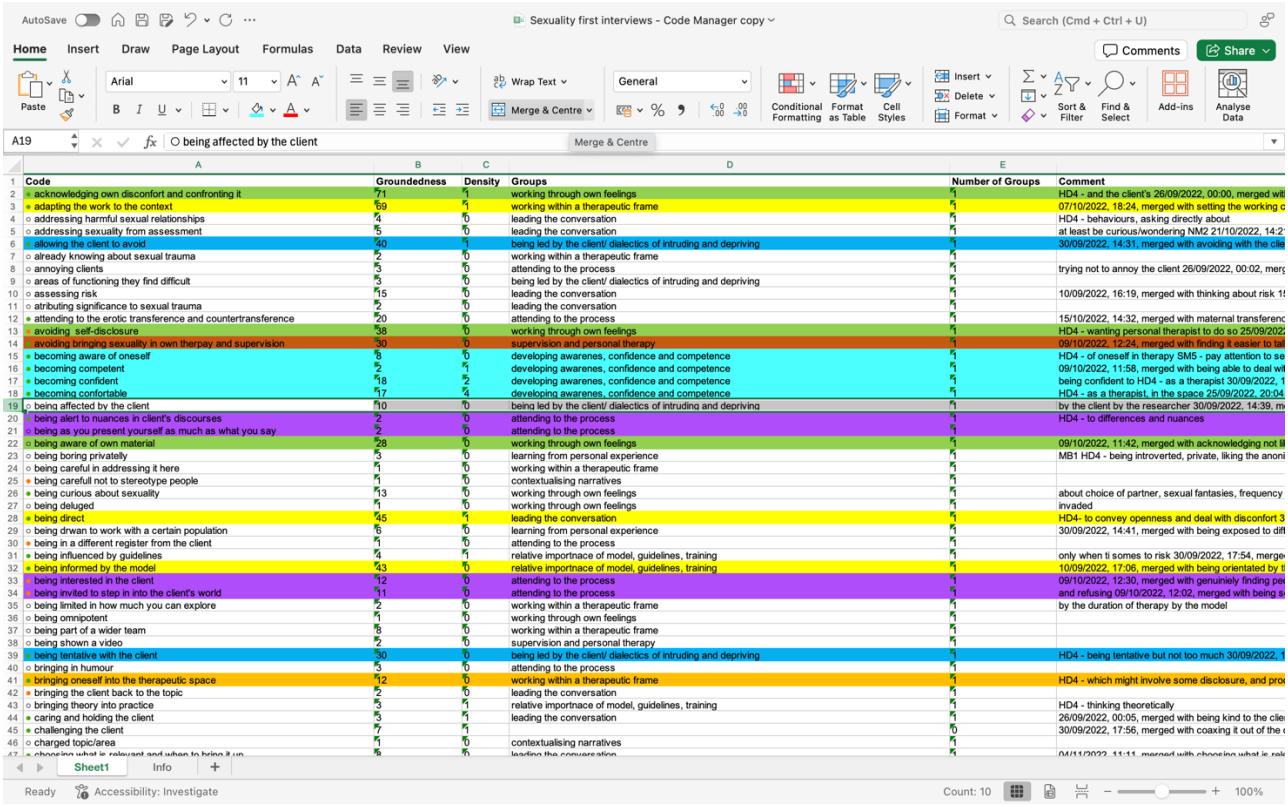
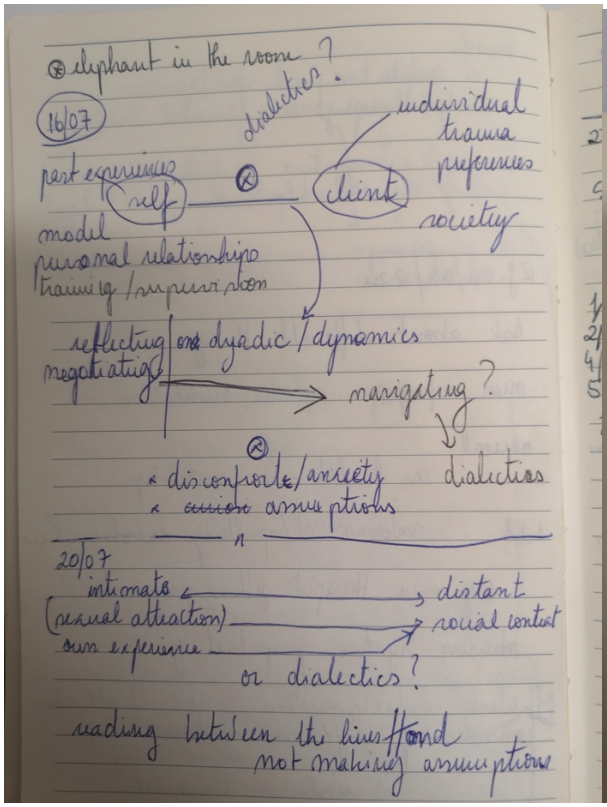
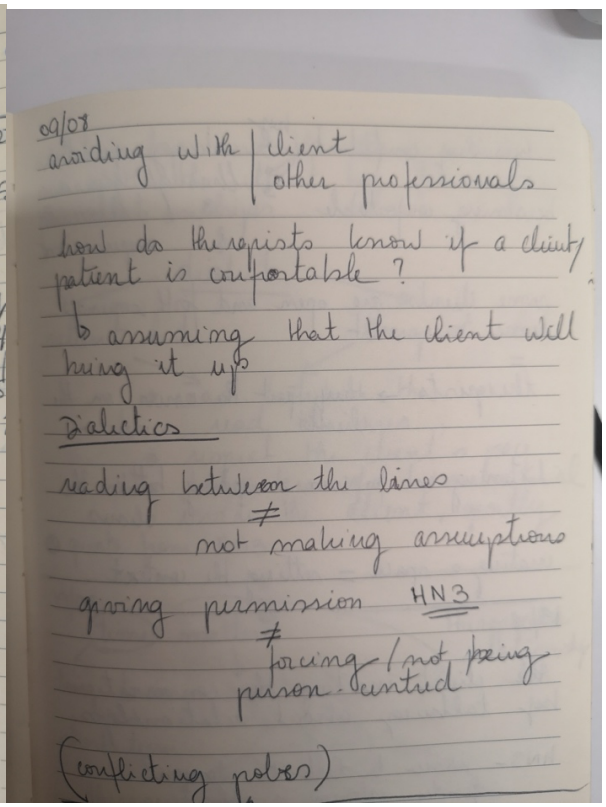
Appendix 9 – Focused coding

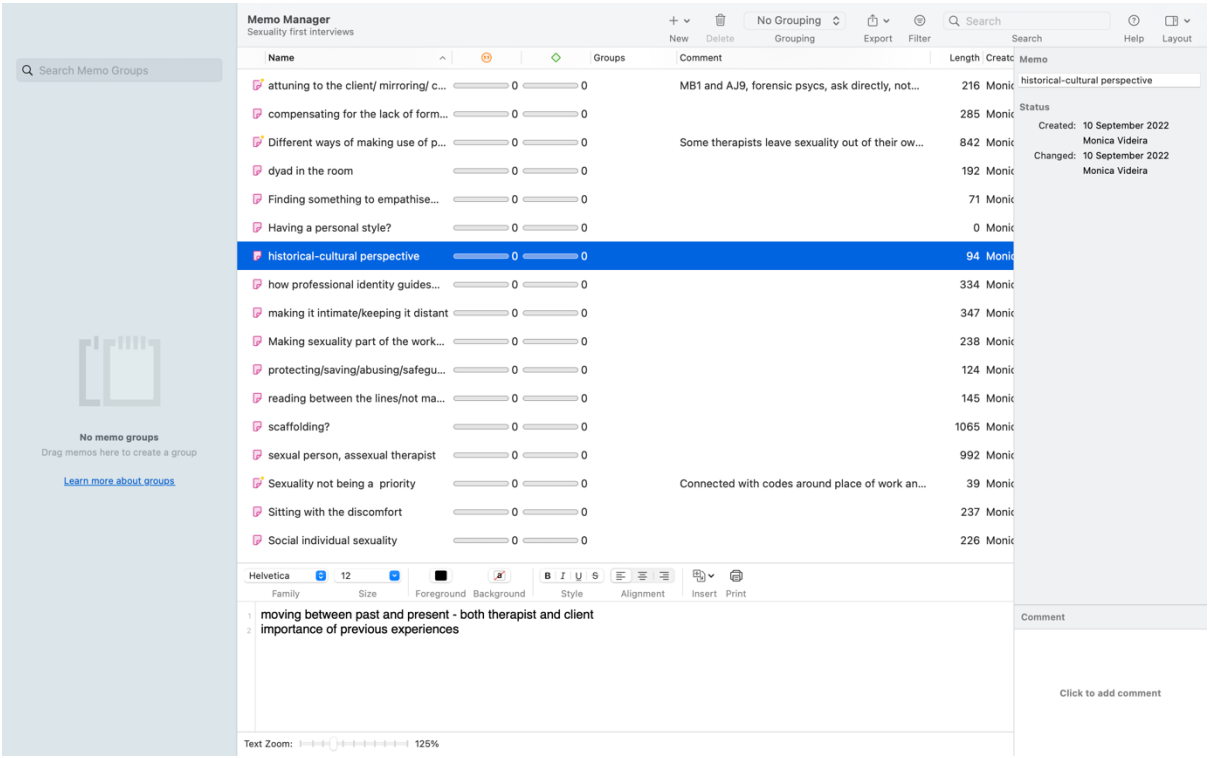


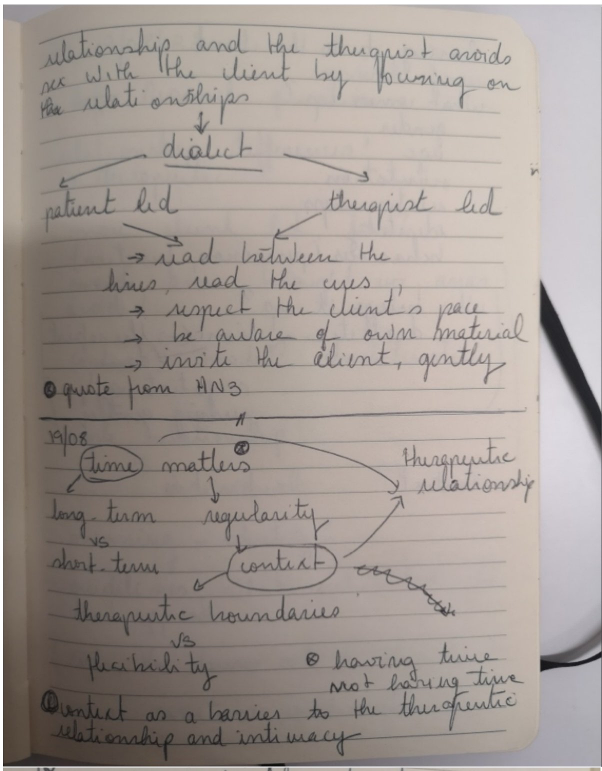


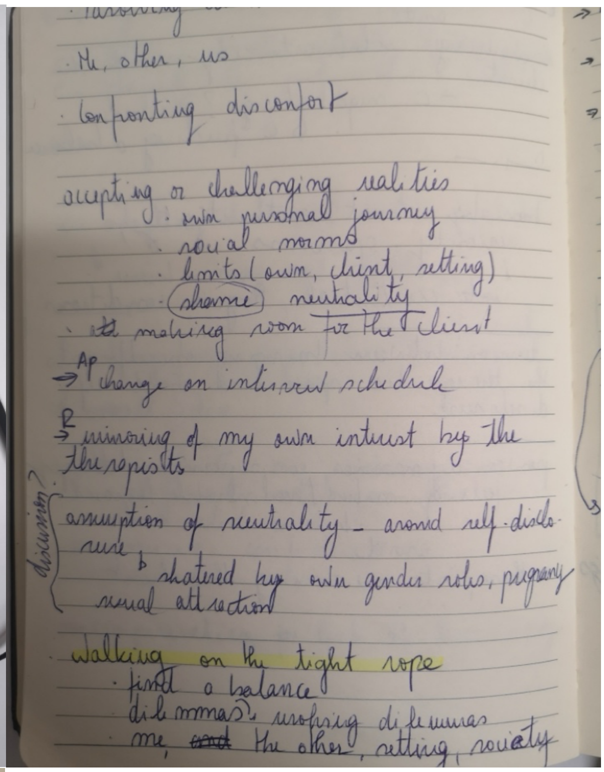
Appendix 10 – Memos

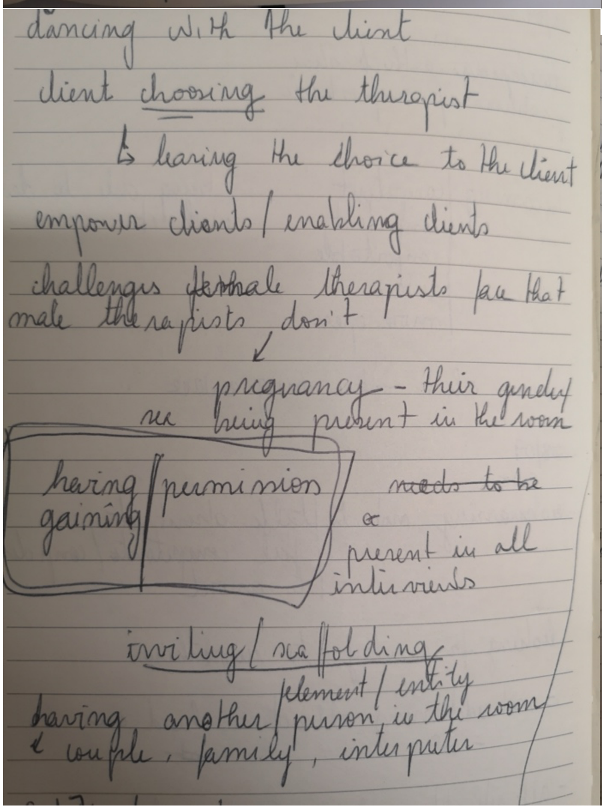


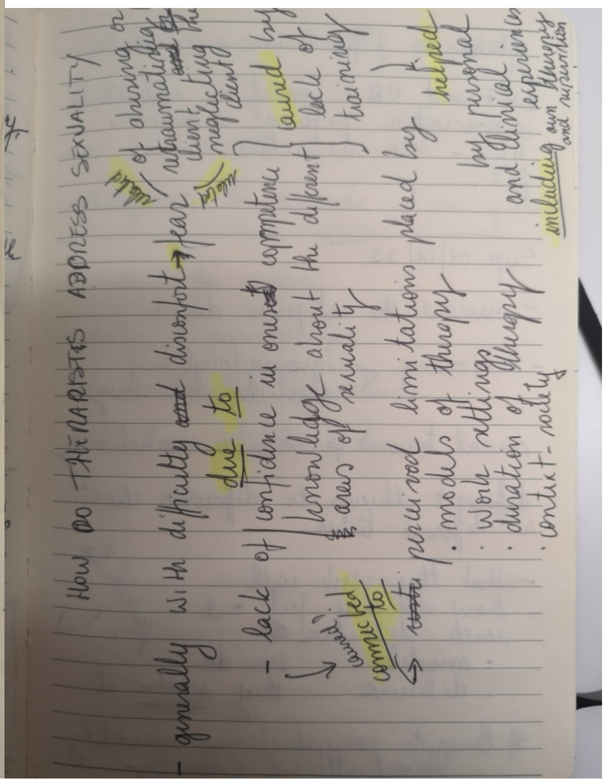




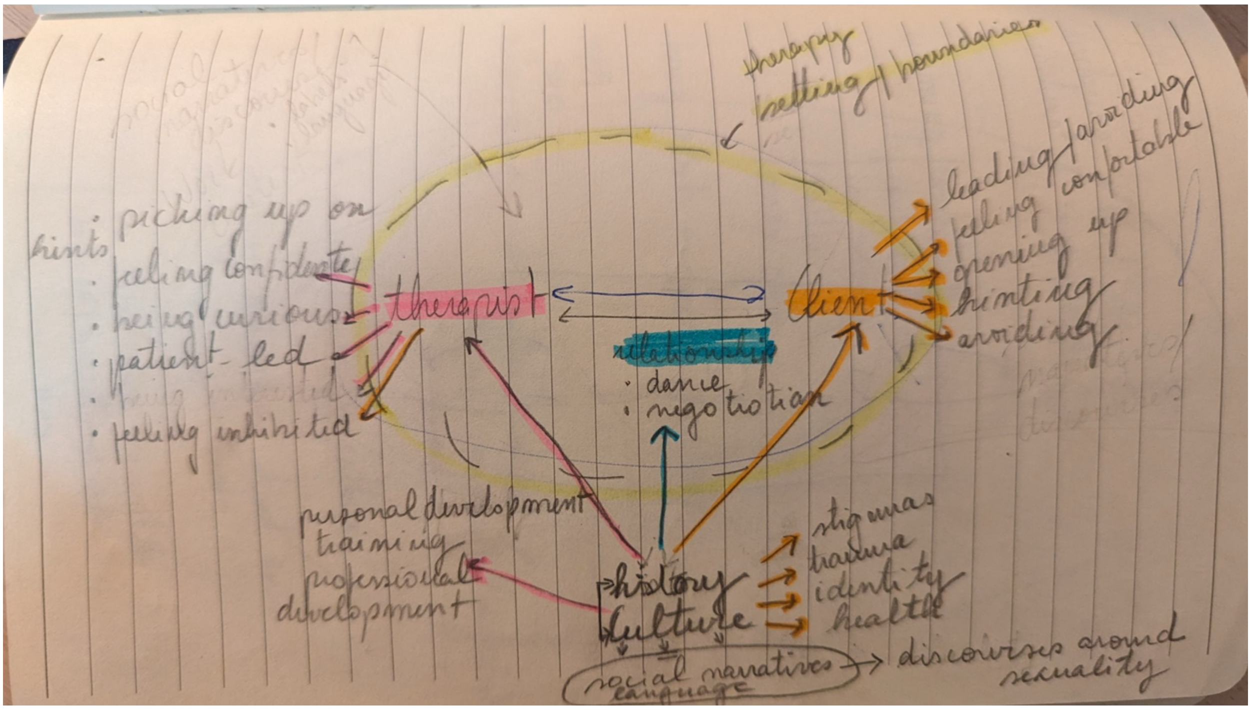

relationship and the therapist avoids
sex with the client by focusing on
the relationships
dialect
patient led
therapist led
→ read between the lines, read the eyes,
→ respect the client's pace
→ be aware of own material
→ invite the client, gently
⊗ quote from HN3
19/08
time matters ⊗
therapeutic relationship
long term vs short term
regularity
context
therapeutic boundaries vs flexibility
⊗ having time
not having time
⊗ context as a barrier to the therapeutic relationship and intimacy

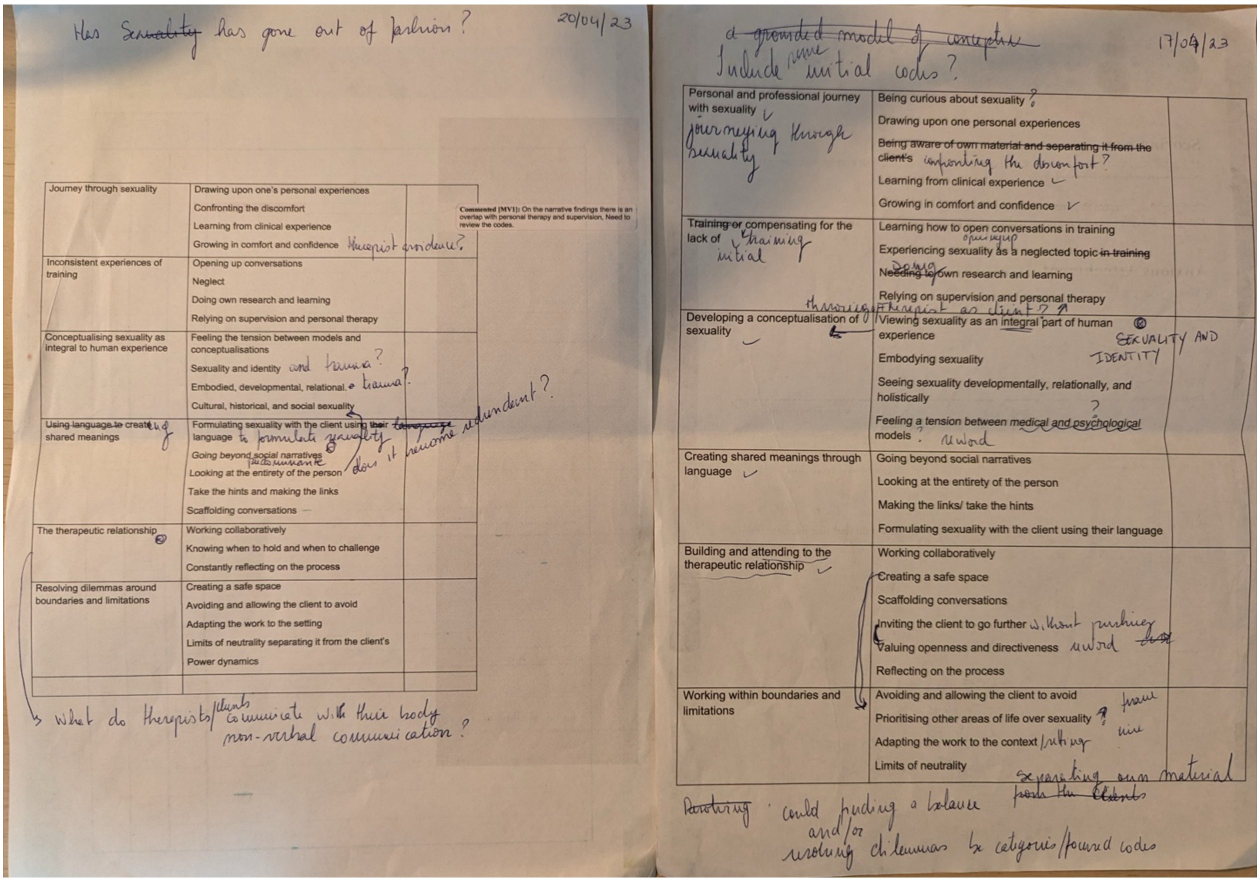

Me, other, us
confronting discomfort
accepting or challenging realities
. own personal journey
. social norms
. limits (own, client, setting)
. (shame) neutrality
. making room for the client
→ AP change on interview schedule
→ R mirroring of my own interest by the therapists
discussion?
assumption of neutrality - avoid self-disclosure
↳ shattered by own gender roles, pregnancy
sexual attraction
walking on the tight rope
. find a balance
dilemmas? unfolding dilemmas
me, ~~and~~ the other, setting, society


dancing with the client
client choosing the therapist
↳ leaving the choice to the client
empower clients / enabling clients
challenges ~~female~~ female therapists face that
male therapists don't
pregnancy - their gender
sex being present in the room
having / gaining | permission
~~needs to be~~
present in all interviews
inviting / scaffolding
having another person / element / entity in the room
couple, family, interpreter


HOW DO THERAPISTS ADDRESS SEXUALITY
- generally with difficulty ~~and~~ discomfort → fear of abusing or retraumatising client, neglecting client
due to
- lack of confidence in oneself competence
avoid by
knowledge about the different areas of sexuality
lack of training
→ connected to perceived limitations placed by
. models of therapy
. work settings
. duration of therapy
. context - society
helped by personal and clinical experience
including own therapy and supervision

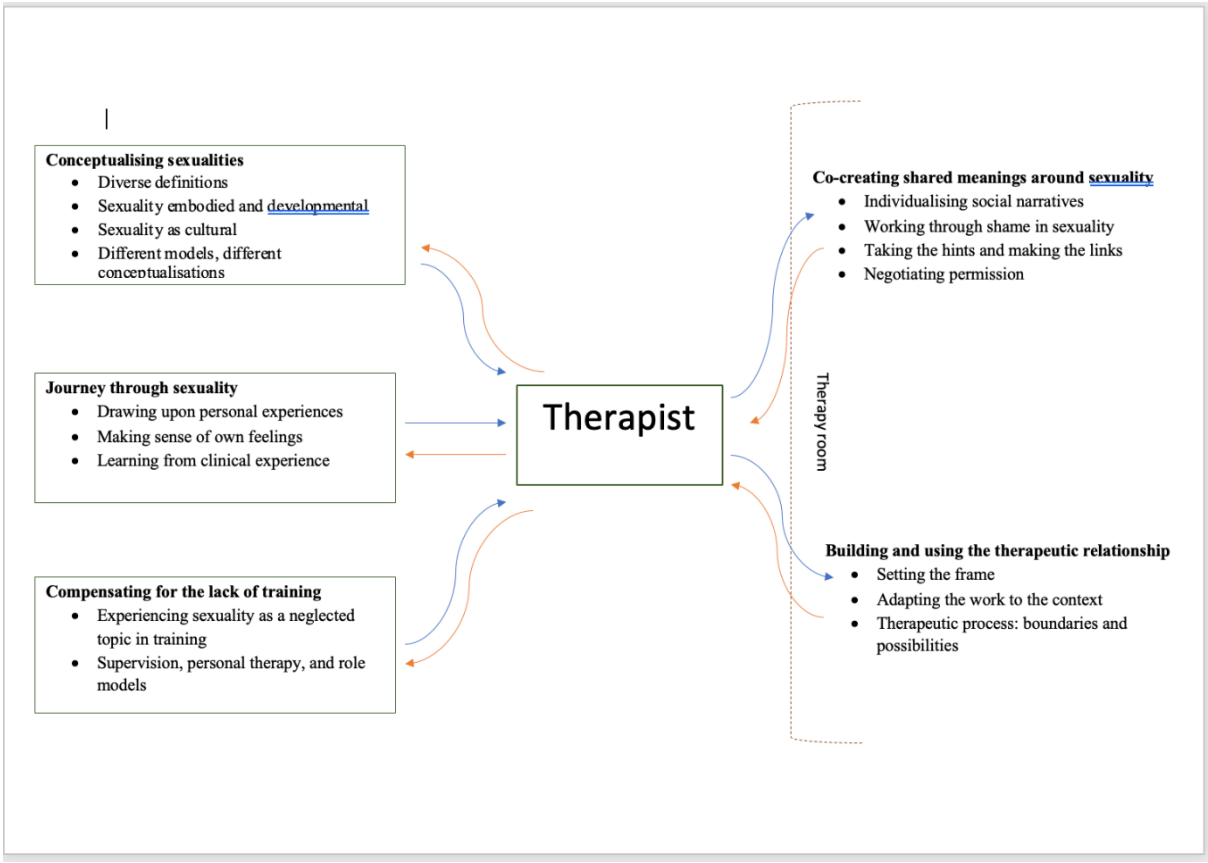
Appendix 11 – Constructing the theoretical model.





Journey through sexuality	Drawing upon one's personal experiences Confronting the discomfort Learning from clinical experience Growing in comfort and confidence
Inconsistent experiences of training	Opening up conversations Neglect Doing own research and learning Relying on supervision and personal therapy
Conceptualising sexuality as integral to human experience	Feeling the tension between models and conceptualisations Sexuality and identity Embodied, developmental, relational. Cultural, historical, and social sexuality
Using language to create shared meanings	Formulating sexuality with the client using their language Going beyond social narratives Looking at the entirety of the person Take the hints and making the links Scaffolding conversations
The therapeutic relationship	Working collaboratively Knowing when to hold and when to challenge Constantly reflecting on the process
Resolving dilemmas around boundaries and limitations	Creating a safe space Avoiding and allowing the client to avoid Adapting the work to the setting Limits of neutrality separating it from the client's Power dynamics

Personal and professional journey with sexuality	Being curious about sexuality Drawing upon one personal experiences Being aware of own material and separating it from the client's Learning from clinical experience Growing in comfort and confidence
Training or compensating for the lack of	Learning how to open conversations in training Experiencing sexuality as a neglected topic in training Needing to own research and learning Relying on supervision and personal therapy
Developing a conceptualisation of sexuality	Viewing sexuality as an integral part of human experience Embodying sexuality Seeing sexuality developmentally, relationally, and holistically Feeling a tension between medical and psychological models
Creating shared meanings through language	Going beyond social narratives Looking at the entirety of the person Making the links/ take the hints Formulating sexuality with the client using their language
Building and attending to the therapeutic relationship	Working collaboratively Creating a safe space Scaffolding conversations Inviting the client to go further Valuing openness and directiveness Reflecting on the process
Working within boundaries and limitations	Avoiding and allowing the client to avoid Prioritising other areas of life over sexuality Adapting the work to the context Limits of neutrality


Conceptualising sexualities
Diverse definitions
Sexuality embodied and developmental
Sexuality as cultural
Different models, different conceptualisations
Journey through sexuality
Drawing upon personal experiences
Making sense of own feelings
Learning from clinical experience
Compensating for the lack of training
Experiencing sexuality as a neglected topic in training
Supervision, personal therapy, and role models
Therapist
Therapy room
Co-creating shared meanings around sexuality
Individualising social narratives
Working through shame in sexuality
Taking the hints and making the links
Negotiating permission
Building and using the therapeutic relationship
Setting the frame
Adapting the work to the context
Therapeutic process: boundaries and possibilities