

***The Topic of Sexuality within the Therapeutic Encounter:
The Therapists Experience and Viewpoint***

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Abstract

This research study seeks to explore psychotherapists' management of the topic of sexuality in the therapeutic dyad. Specific interest is directed toward the real, authentic and 'felt' experiences of the psychotherapist in working with this topic in the therapeutic relationship. Much of the existing research regarding the clinicians' perspective on the subject of sex and sexuality in the counselling room is quantitative in nature. Qualitative data on this topic is finite. As such, a gap emerges in the research. This dissertation goes somewhat towards addressing that gap by conducting a qualitative study using the insight of five practicing clinicians. The methodology used is semi-structured interviews. The data is codified and collated into a thematic analysis. The focal points of interest gleaned in the existing and current research include the therapist's training, supervision, transgressions, erotic transference, attitudes, morals beliefs and comfort levels in managing this delicate topic with clients. However, this study found that early formation of attitudes and beliefs in addition to the different disciplines of psychotherapy that therapists were trained in significantly influences their management of sexuality in the therapy room.

Introduction

According to the World Health Organisation (2011), sexuality is regarded as ‘a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction.’ It goes on to say that ‘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’. In other words, sexuality is intrinsically interwoven into our very beings. Bancroft (1990) states how one’s sexuality impacts on the individual on a physiological, biological, psychological, social, economic, political, cultural, ethical, historical, legal, spiritual and religious level. As such, human sexuality is complex.

Historically, it seems that there has been a fear within the therapy industry to research and analysis itself reflexively in regard to how the topic sexuality is handled by therapists (Pope et al 1993). This fear appears to be related to worries about sexual indiscretions and an abuse of the power dynamic in the therapeutic relationship that occurs on occasion. Pope (1993) relays that in the 1960’s, a psychologist named Harold Greenwald was nearly expelled from a clinical psychological association for even suggesting that a study into the phenomenon of sexual intimacies by therapists and their clients be carried out. It was only in the 1980’s that these type of studies were done and published at all. And so, this perpetuates a sense of taboo to the subject matter of sexuality in the therapy room and likewise within the therapy world too. It’s as if discussing sexual feelings in therapy or even being aware of sexual attraction/erotic transference within the therapeutic exchange makes one guilty by association, of a digression. Therefore, the topic of sexuality is unfortunately often left out in

the cold as a matter that isn't even there. This is extremely unfortunate when one considers that Freud (as cited by Weinert, 2009) believed "the behaviour of a human being in sexual matters is often a prototype for the whole of his other modes of reaction in life" (p.188).

Research aims and objectives

Aim:

The aim of this research is to explore the topic of sexuality within the therapeutic encounter from the therapist's 'felt' sense and viewpoint.

The objectives of this research are as follows:

- To investigate what informs the therapist ease or dis-ease in exploring the area of sexuality with clients
- To examine the therapist's ability to facilitate this process of deep exploration into the topic of sexuality in the therapeutic encounter with clients.
- To examine the impact that this exploration has on the therapist.

Chapter One – Literature Review

1.1 An overview of the topic of sex and sexuality in psychotherapy:

Up and until the nineteenth century, there was a purely moralistic view of sex and sexuality in Western society. Goodwach (2005) points out that the sexual ideology of the time was: “monogamous marital sex for procreation” purposes (p.156) Men were provided with the right to have a sexual appetite whereas a women’s purpose sexually was to satisfy a mans desire. The onset of this dogma was influenced by Christianity. In addition, Christianity developed into an “attempt to attain perfection through subjudgation of the body, with full human consciousness being achieved by suppressing the sexual energies” (p.156)

Sigmund Freud founded the theory and discipline of psychoanalysis, the first form of ‘talking therapy’. It heralded the relevance of one’s sexuality firmly within any school of therapy. The libido theory (1905) decrees that there is an ongoing struggle for expression and satisfaction (the pleasure principle) of one’s sexual instinct/drive between the id, the ego and superego. The ego ensures that one’s survival needs prevail over this anticipated relief (reality principle). Freud (1920) later revised this to the dichotomy between one’s life instinct and death instinct.

In fact, Freud (1905) posited that sexuality begins from birth and that sexuality is intrinsically linked to the development of personality, i.e. through the oral, anal, phallic, latency and genital psychosexual stages of development; and through the oedipal/electra complexes. The eronogenous zones which includes primarily the mouth, the anus and the genital organs are important in the development of the personality. For example, there is pleasure derived from

the satisfaction of these basic vital needs and independent needs (i.e. thumb sucking) via the erogonous zones. Infants discover how to manage the ‘irritating excitations’ and experience relief. In addition, an infant’s personality becomes compromised when the child sees their parents’ disapproval of thee behaviours that involve the eorgoneus zones. Anxieties, frustrations and defences begin from this place and affect the growing personality. Psychoanalysis endeavours to bring awareness to the individual of these complexities; conscious and unconscious, via probing defences, free associations, fantasy and dreams / wish fulfilment and addressing transferences in the therapeutic relationship.

Research carried out by Alfred Kinsey et al in the 1940’s challenged the still moralistic western view of sex and it determined what is normal sexual practice, behaviour and orientation in society. The research “drew a distinction beweeen what society deemed to be normal and what people actually did” sexually (Goodwach, 2005 p.157). In fact, variations in sexual behaviour were so great that it was meaningless to make any kind of definition of what was normal for both men and women alike. Masters and Johnson (1966) are credited with revolutionising society’s understanding of the differing ‘human sexual response cycles’ of men and women, named the excitement, plateau, orgasm and resolution phases. The sex therapy industry really grew from this place and has contrubuted greatly to working with sexuality in therapy from a medicalised and ‘fix it’ perspective. Kaplan (1974, 1975) highlighted sexual desire as a crucial element in the experience of sexual difficulties. She also recommended incorpoating psychodynamic therapy into any dialogue had about these problem areas.

Today in the therapy profession, it appears that the topic of sex and sexuality has become divided into three distinct streams. Firstly into a scientific and medicalised sex therapy approach specialising in dysfunction, behaviour and compulsion. Secondly, into the psychoanalytic understanding described earlier and thirdly into a combination of the preceding two which fit under the humanistic and psychodynamic schools of therapy that developed out of psychoanalysis. Object Relations which was championed by Fairbairn is an offshoot of psychoanalysis (Gomez, 1997). Fairbairn posited that individual's are primarily relational beings, i.e. object seeking. As such, the early development of an infant is primary to who and how he/she becomes as an adult. However, it is the relationship and relating to another that is key to this growth process. Carl Rogers introduced the world to the concept of person centredness. This resulted in the acceptance that 'being' with a client; accepting, empathising, being congruent and remaining unconditional facilitates self awareness and growth. It is with a sense of these concepts that clinicians today generally meet their clients within the privacy of the therapy walls. This too facilitates and enhances a persons ability to talk openly about the 'taboo' subject of sex and sexuality in therapy.

The literature ponders on the psychotherapist's willingness and ability to talk about the topic of sex and sexuality in a client's life. The literature proceeds to draw emphasis towards the relationship with self in all its guises as being intrinsic to the client's personal developmental process. Sexuality is a core part of who one is and how one relates to the world (Orbach, 1999; Ford and Hendrick, 2003; Risen, 2003; Timm, 2009). "The expression of sexuality is a window into who each person is and how they relate to each other" (Schnarch, 1991, p.20). It would seem natural then that issues regarding the vast topic of sex and sexuality would come up in a psychotherapy session. Yet, it is apparent that addressing this important area

can be extremely challenging for many psychotherapists and clients alike. The fundamental question is what stops this from being explored?

1.2 The topic of sexuality in the counselling relationship:

The fact is there is a major challenge facing a psychotherapist who boldly goes where many have specifically chosen not to go before, when talking about the topic of sex and sexuality in client work. The basic qualities of empathy, unconditional positive regard and congruence attributed to Rogers may be tested to their limits. As Ridley (2009) points out, there is a consistent stream of challenge to one's morals, orientation, experience, fantasies, excitations and prejudices when one embarks on a sexual exploration with a client. One's feelings are tested to their limits ranging from fear to joy, shame to stimulation, guilt to power. A psychotherapist needs to be able to hold the boundaries of self and the other in a clear, strong and safe way.

Additionally, as Butler, O'Donovan and Shaw (2010) argue; the topic of sex and sexuality has always been historically and culturally determined; resulting often in controversy and secrecy in society. Society has developed in such a way that discussions about one's sexuality are taboo, embarrassing and exposing and it has become the norm to avoid talking about the subject area in general. Similarly, what is considered 'normal' sexually by society affects how individuals' view this topic and it colours what may or may not be brought up in the therapy room too. Psychotherapists' and clients' alike are susceptible to this discourse and it affects attitudes, beliefs, morals and behaviours' of both parties and in turn one's feelings too.

Yet, any issues that arise with one's sexuality are important and are common among the general population (Timm, 2009). Research indicates that up to 52% of men and up to 63% of women report problems in this area (Laumann, Michael & Kolata, 1995; Read, King and Watson, 1997). These issues often need to be discussed with another to be understood. Sexual issues that may arise are vast. An array of issues such as sexual dysfunction, sexual health, intimacy in relationship, pregnancy, abortion, miscarriage, orientation, abuse, rape, responsibility, affairs and sexual dissatisfaction may be discussed. Logically, it is particularly essential to have the professional competence, a wide array of knowledge and an excellent skill set when dealing with the area of sex and sexuality as a psychotherapist (Giarni, 2006).

It is apparent therefore how important therapy is to the exploration of the topic of sexuality in an individual's life. The therapeutic alliance is an intimate, diverse and deeply personal meeting of two minds. It engages one into an exploration of the most profound questions of our humanity itself (Orbach, 1999). Orbach explains that one's sexuality and what it means to the individual, and its affiliation to trust, love, betrayal and hate is played out and tested in this therapeutic relationship. The space created in the therapy room provides a stage where the individual has the opportunity to participate, witness and learn about oneself in a real way. In exploring the topic of sexuality with clients, the psychotherapist provides a unique and ultimately freeing way for the individual to connect with the authenticity and innateness of being a sexual human being in all its glory. That being said, one can understand why it is so vital to study the psychotherapist and his/her relationship to sexuality in the therapy room and to the growth of the therapy industry itself. This is particularly so. Firstly in regard to his/her ability to discuss the topic of sexuality, secondly in the psychotherapist's comfort in doing so and thirdly in psychotherapist's awareness of his/her own barriers against the examination of human sexuality.

1.3 Training and education:

One of the major stumbling blocks identified that prohibits the discussion of sexuality in psychotherapy today is a lack of training (Kelly, 2009; Pope et al 1986, 1993; Timm, 2009). This clearly suggests that the training of psychotherapists in dealing with sexuality is somewhat left wanting. Kelly (2009) believes that there is a need for a more cohesive and appropriate training in sexual awareness work, theory and practical implications in the therapy room. This seems to echo studies that have been carried out that report professionals appearing to be apprehensive, unclear and unable to bring up the topic of sex (Fyfe, 1980; Giami, 2006; Haboubi and Lincoln, 2003; Yallop and Fitzgerald, 1997). This shortcoming brings into question the professional competence of our trainees and accredited therapists in handling sexual discussion in the therapy room.

If sexuality is a topic not discussed and explored in one's training as a professional therapist, the knowledge and confidence in addressing this with clients may often be missing, according to Harris and Wenner Hays, (2008). There have been studies carried out (Kirkpatrick, 1979; McConnell, 1979; Zwibelman and Hinrichseen, 1977) that have found that detailed training in the area of sexuality facilitates the therapist to explore and question their own comfort, feelings, beliefs, biases, attitudes and personal relationship with all things related to the topic sex and sexuality.

The type of exposure that a therapist in training or accredited therapist receives regarding sexual awareness and knowledge certainly impinges on the ability to bring the topic of sex into the therapy room at all. Anderson (1986) describes three important factors intrinsic in

any training that explores the topic of sex and sexuality. These are; firstly, to provide the facts and information about the topic; secondly, to facilitate activities that enable students to examine their own beliefs and attitudes to sexual material; and finally, it is crucial to give a sufficient length of time to allow students to consider and integrate any changes in self that may arise out of this process. It appears that the self-examination involved in the training process leads to normalization of one's own sexual self and of sexual discussions. This facilitates an openness and awareness in the therapist regarding any potential sexual problems clients' may have. It induces a sense of relaxedness and freedom to talk openly about sexual issues. In fact, it is often discovered that at some point in the training or shortly just thereafter that therapists find an awareness of new comfort in discussing sexual issues.

On the other hand, a quantitative study carried out by Ford and Hendrick (2003) of professional therapists showed that over 75% plus of 1,000 respondents were trained in the area of sex and sexuality. However, the respondents had a neutral response regarding their training being preparatory to them in working with sexuality in therapy. In fact, eighty percent of respondents stated that 25% or less of their practice was related to sexuality issues, 16% reported 26-50% and 4% reported 51-100%. This suggests that the training provided on the area of sexuality within psychotherapeutic institutions needs to be reviewed and worked on in greater detail.

1.4 Values, Beliefs, Attitudes and Morals:

Values, beliefs, attitudes, morals and comfort levels have been referenced in the literature reviewed as influential in sexuality and sexual issues being discussed in the therapy room

(Harris and Hays, 2008; Ridley, 2006; Ridley, 2009; Timm, 2009). While knowledge regarding sexual issues is crucial as a psychotherapist, comfort with this topic facilitates the imparting of this knowledge in an effective, relaxed and unencumbered way (Graham and Smith, 1984; Harris and Hays 2008).

Giami (2006) quotes Foucault (1963) where he describes how the skills required and acquired in working with sexuality emerge only through 'doctor-patient interaction'. As such, competency in managing one's own subjective "experiencing" and one's responses to a client struggling in the sexual realms of their life is essential (Russell, 1993). Discomfort with sex, embarrassment and even the messages the therapist received in their own life about sex influence their ability to talk about sexual issues in session (Ridley 2006, Timm 2009).

According to the literature, there are a myriad of factors that determine and shape a psychotherapist's attitudes, values, beliefs and comfort in regard to the topic of sex and sexuality. Culture, family of origin, religion, past sexual experiences, current sexual experiences, sexual education, sexual self-perception and training as a psychotherapist are among the many influences (Anderson, 1986; Ford and Hendrick, 2003; Haboubi and Lincoln, 2003; Harris and Hays, 2008; Ridley, 2009; Timm 2009).

It is the responsibility of the psychotherapist to address these struggles in order to free himself or herself up to be available to the client regardless of what sexual issue is brought up. Otherwise, the psychotherapist may often ignore, dismiss or downplay what is occurring in the therapy room due to their own personal demons and the inability to be fully there for a

client with empathy, unconditionality and positive regard. The psychotherapist's own overwhelming feelings or uncertainty disrupts the process of therapy completely (Mann, 1999; Searles, 1959). For example, a presenting issue of depression or low self-esteem in therapy may be related to sexual problems, but if the psychotherapist is reluctant and doesn't ever bring the sexual side of one's being into the therapy room, he or she is not inviting in or creating a possibility for the client to see that sex is relevant and important in the therapeutic alliance.

On the other hand, oftentimes, a psychotherapist's own perceptions may inadvertently affect a client in changing their own beliefs (Arizmendi, Beutler et al, 1985; Beutler, 1979; Ford and Hendrick, 2003). Ridley (2006) quotes Orlinsky and Howard, (1978, p.299) in stating that "the patient's perception of the therapist's manner as affirming of the patient's value is positively and significantly associated with good therapeutic outcome." Research indicates that sexuality is an area where clients and therapists tend to have differing opinions. This illustrates that therapists are more inclined to have more liberal sexual values than their clients (Roman, Charles and Karusu, 1978; Khan and Cross, 1983). At the same time, the research carried out by Ford and Hendrick (2003) supports a previous study carried out by Jenson and Bergin, (1988) that "the practice of therapy is not value free particularly where sexual values are concerned." The Ford and Hendrick (2003) study implies that psychotherapists are mindful of their own values and try to reduce the effect this may have on clients. This quantitative study found that psychotherapists dealt with dilemmas regarding values and attitudes by referring clients on to other therapists, by consulting with colleagues and by consulting with peers and in ongoing to supervision.

1.5 Supervision:

Supervision is a cornerstone of every psychotherapist's clinical practice. Every training institution, school of therapy and professional regulating body of psychotherapy acknowledge how indispensable it is to the work. The Irish Association of Humanistic and Integrative Psychotherapy's (I.A.H.I.P.) code of ethics paragraph 9.1 clearly states the necessity for psychotherapists to attending regular supervision. This is echoed in the both the Irish Association of Counselling and Psychotherapy's (I.A.C.P.) and the Association for Psychoanalysis and Psychotherapy in Ireland (A.P.P.I.), sections 4.1 and 6 respectively.

Supervision is an important arena for exploration of difficulties and process issues that come up in therapy with clients (Butler, O'Donovan and Shaw, 2010). Morals, attitudes, taboos, beliefs fears, embarrassment, shame, self-doubt and life experiences as referred to earlier may affect the psychotherapist in their willingness to bring the topic of sexuality to supervision (Butler, O'Donovan and Shaw, 2010; Long and Serovich, 2003). Additionally, the wish to develop one's skills and the busy-ness in the practice and workplace are described as reasons that a psychotherapist evades a deep self-reflection (Pope & Tabachnick 1993; Pope et al 1993).

Allowing a space for self-reflection in supervision for the therapist to explore how one might address the topic of sexuality with clients and to look at their own subjectivity about the topic is crucial in supervision. It promotes a sense of stability and safety within the supervision process and subsequently in the client work. Finding out for oneself what skills, knowledge

and experience are important in addressing the topic of sex in psychotherapy may often come about through regular supervision (Giarni, 2001; Mann, 1997; Ridley, 2009).

Supervision is also an ideal space for the psychotherapist to reflect on what the nature of their relationship with clients is, i.e. what exactly is occurring between the two parties in the counselling relationship. However, it is common that the psychotherapist's need to upskill and to know what to do with a client may block their own exploration of the subjective and inter-subjective experiencing within the therapeutic relationship. It is overlooked. The transference and counter-transference within the therapeutic dyad is missed (Ridley, 2006).

1.5 Erotic transference and counter transference:

When one considers the cocktail of sexual emotions, attraction, erotic transference/counter-transference that may arise in the therapeutic alliance when discussing the topic of sexuality; it is possible to empathise with the psychotherapist's reluctance to delve into the area. However, issues of this kind emerge frequently in therapy (Celenza, 1991; Giovazolias and Davis, 2001; Pope et al, 1986; Pope, 1993; Ridley, 2006; Solomon, 1997). Awareness and acknowledgement of this and the ability to handle sexually charged transference and counter-transference encounters are imperative to the relationship between psychotherapist and client. Pope (1993) points out; it is also crucial so that the psychotherapy industry may "understand, prevent and respond to violations of the prohibition against sexual intimacies with patients" (P9).

It has long since been the consensus of all professional psychotherapy bodies that engaging in sexual intimacies of any kind with clients is wrong. It is prohibited and is regarded as an abuse of the therapist's power dynamic, their boundaries and the vulnerability of the client. The IACP, IAHIP and APPIs' codes of ethics referred to earlier consider any such act to be unethical. However, transgressions of a sexual nature occur (Celenza, 1991; Nachmani & Somer, 2007; Pope, 1990; Schoener et al, 1989; Sonne & Pope, 1991; Tansey, 1994).

Freud (1915 [1914]) considered that 'transference love' occurs. By the very nature of the analytic setting, it is "provoked....greatly intensified by the resistance which dominates the situation; and...is lacking to a high degree in a regard for reality" (p162). It appears that Freud theorised that the 'love' and erotic transference in therapy can be "an expression of resistance" and often manifests in a client when something in the unconscious or a painful piece of his or history is on the cusp of awareness. Mann (1997) describes the erotic transference as signifying the "patients greatest wish for growth" (p9). Other researchers agree (Giovazolias & Davis, 2001; Kumin, 1985; Searles, 1959). So what is the clinician to do? And how can he or she handle this?

According to Freud (1915 [1914]), reciprocating this 'love' is out of the question. The correct response is to remain and retain the neutrality acquired through "keeping the counter-transference in check" (p164). Thus, It is the clinicians responsibility to facilitate the client to work through her "capacity for love that is impaired by infantile expectations" until he/she is able to fully understand his/her needs (p169). Mann (1997) advocates engaging in discussion of the erotic. He believes that the therapist is the transitional object that facilitates a client to form a new relationship to self and to sex by allowing their erotic content to be held

discussed, processed and prized. He states that seeing the love and the erotic as resistance in therapy makes the exploration of it dangerous rather than illuminating and freeing. Mann does concur with Freud in stating that he is sceptical of any merits there is in a clinician revealing his or her desire for the client.

The literature reviewed places emphasis on the complexity and tenuousness comprised in the discussion of the topic of sex and sexuality. It stems from the individual, society and history. It pervades into psychotherapy room and the psychotherapy dyad too. A density of information and research about what sex and sexuality is and why it is important has been provided and explored. This literature delves into the therapists training, values, morals, beliefs, comfort, avoidance, education, discussing of sex with clients, transference, erotic transference and counter-transference. However, it is apparent in this review, that the majority of research carried out has been of a quantitative nature. Little has been done of a qualitative nature to examine the authentic, real and felt experience of the therapist. It is with this research seeks to uncover.

Chapter Two – Research Methodology

2.1. Rationale for methodological approach:

The main purpose of this thesis is to acquire an understanding, from the perspective of the psychotherapist as to what it is like to explore the topic of sexuality in therapy with clients. There is a particular curiosity about what the psychotherapist's feelings and experiences are in regard to this complex topic. The researcher finds it interesting to discover that while there have been a number of quantitative studies completed on this specific subject, there is a dearth of research of a qualitative nature. The production of qualitative data "captures the research subjects' genuine experiences and understanding" (Ruane, 2005 p12). For this reason, one to one interviewing forms the basis of this research. The interview questions are largely open ended and the questions sometimes varied in sequence.

McLeod (2001) defines qualitative enquiry as offering "a set of flexible and sensitive methods of opening up the meanings of areas of social life that were previously not well understood" (p.1). McLeod (1998) also suggests that "the fundamental goal of qualitative investigation is to uncover and illuminate what things mean to people" (p78) This avoids the more prosthetic, inflexible pre-articulation that is manifest in more structured, survey type techniques used in quantitative research. (Oakley, 1981) There is an openness and receptivity to listen and hear what the interviewee says without bias or direction in the use of semi structured interviews. It gently allows for the interviewee to reach one's own hypotheses and conclusions about a topic that is highly sensitive and private in nature to the individual. It avoids any reconstruction of words by the interviewer (Morgan, 1997). . Significantly, the research in this particular study is "reflexive" in nature as it provides a fresh sense / "reflexive knowing" to the psychotherapy profession. (McLeod, 2001 P4). As such,

it naturally employs the 'heuristic inquiry' method developed by Moustakas (1994) in the methodological approach adopted.

2.2. Sample:

A random sampling strategy is used to recruit the participants initially. A listing of accredited practitioners was accessed from each professional association. Every third, sixth and ninth name was picked from these databases and contact was made via email in order to recruit interviewees. This rendered no success at all. As a result, a sampling technique of 'snowballing' was employed. The 'snowball' method is a non-probability sampling approach in which each person interviewed may be asked to suggest additional people for interviewing. In this instance, two eligible representatives came forward and introduced the researcher to other members of the psychotherapy population willing to partake in the study.

2.3. Participants:

There are five participants of the one to one interviews conducted as part of this research piece; three female and two male. The interviewees range in age from twenty nine to sixty. All participants are trained professionally by training institutes within the counselling, psychotherapy and psychoanalysis tradition. Three psychotherapists are accredited by the Irish Association of Counselling and Psychotherapy. One participant is accredited by the British Association of Counselling and Psychotherapy and the National Association of Pastoral Counselling and Psychotherapy. The final participant is accredited by the Association for Psychoanalysis and Psychotherapy in Ireland. Altogether the participants'

therapeutic experience as practitioners totals thirty three in years. Individually, this ranges from six to fifteen years.

2.4. Procedure:

2.4.1 Data collection:

As emphasised, the current research study uses the qualitative method of one to one interviews to investigate the effect/ability (emotions/implications) of exploring the topic of sex and sexuality with clients in psychotherapeutic work. By using this method, the researcher's interest affects the responses given by the interviewees'. Therefore, the interviews in the current study carry a directive of a "conversation with a purpose" (Sanders and Wilkin, 2010 P. 138) thus facilitating a fluidity and flexibility. The questions used are devised to act as starting points and the interviewer is prepared to manage and develop any unexpected factors (Mason, 2005). As such, the interviewee naturally conveys his or her own narrative to the researcher rather than it being constructed for her (Bowser & Sieber, 1992).

2.4.1.1. Semi-structured interviews:

"The goal of any qualitative research interview is ... to see the research topic from the perspective of the interviewee, and to understand how and why they come to have this particular perspective." (Cassell & Symon, 2006, P.11) In this instance and as referred to earlier, the researcher is a psychotherapist and is applying a reflexive inquiry to the interviews. There is a danger here that the researcher can become too involved or directive in his/her questioning and goals of the research. However, it is advantageous in that it is

possible to use one's skills as a psychotherapist to use in creating an appropriate space and means of enquiry with interviewees.

Lofland (1971) describes the "process of creating a list of potential questions, arranging them into groups according to differing themes to be explored" (McLeod, 2003: P74). While the open ended questions developed for this research piece are formulated and based on the findings of the literature reviewed, emphasis is placed on trying to remain assumption free regarding any responses the interviewee may provide when replying. The interview questions (see appendix I) are used as a guide, they could not be predetermined and the sequence of questions differs on occasion.

It can be stated that there is a delicate balance involved in choosing the qualitative method of interviews. There is a compromise between managing "the data flow in order to quantify your results and collecting data that has the richness, spontaneity and natural quality that you require" (Sanders and Wilkins, 2010 p135). Fontana and Frey (cited in Clough et al, 2002 p.103) write that "interviewing is one of the most common and powerful ways in which we try to understand our fellow human beings." The method of data collection used in this instance is semi structured interviews. To ensure the efficacy of the interview process, a practice session is carried out with a colleague. No changes are deemed necessary. Each interview session is approximately forty five minutes in length and is audio taped for authenticity with the permission of the participants.

Finally, in the true spirit of qualitative research interviews, the researcher endeavours to ensure that the interview is a positive experience for the interviewee. “The interview is a conversation where two people talk about a theme of interest to both parties. A well carried through qualitative interview may be a rare and enriching experience for the interviewee” (McLeod, 1998 p.81). Indeed, one of my interviewees did state, at the end of the interview, that she had enjoyed the experience.

2.5. Data analysis / thematic analysis:

“Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data.” (Braun & Clark, 2006, p.79) The five interviews recorded were transcribed verbatim. The very time-consuming process of transcribing, together with repeated readings of the text, enabled the researcher to get to know the data in detail. The coding involves several stages derived from the thematic analysis model advocated by Braun and Clarke (2006). The researcher initially uses open coding in which she simply creates categories that emerge from the dataset. (Gibson, 2006) With this method of coding, although codes are directed by the research questions, these codes themselves are not determined before the analysis begins (Maguire & Delahunt, 2009). After the initial codes are created, they are refined by means of combining or merging them (Gibson, 2006). This is done by exploring the codes’ properties and dimensions (Ezzy, 2002) which leads to the development of a better understanding of the codes (Anderson, 2006). Therefore this method of coding is an iterative process. A number of codes initially emerge from the data itself.

“A theme captures something important about the data in relation to the research question, and represents some level of *patterned* response or meaning with the data set” (Braun &

Clark, 2006, p.82). I chose my themes, because I believed that they represented the authentic perspective of the therapists handling of sexuality in the therapy room, and because they occurred consistently throughout all the interviews as opposed to just occurring in one particular interview, as described in Braun & Clark (2006). I reconsidered my themes a number of times, and eventually decided to confine myself to three. I chose not to label these sub-themes as I believed them to be self explanatory within the three main themes.

In arriving at my findings and conclusions I took an “essentialist/realist approach” to my analysis which enabled me to take the language and experience of the counsellors/therapists in the centre as articulated by them. (Braun & Clark, 2006)

2.6. Ethics:

Ethical approval for this research was provided by the college ethics committee in 2011. The British Psychological Society (2002) states that participants in psychological research have the right to have the information they provide remain confidential. The interviews are audio recorded in accordance with ethical guidelines to maintain accuracy. Participants were informed that they were being recorded.

In this present study, the researcher has removed any identifiers (e.g. place names, other people’s names) from vignettes that are used in the present dissertation. Where vignettes are used these identifiers are replaced with parentheses (e.g. [place name]). An information sheet and consent form (see appendix II) is used to inform the participants of anonymity, of the right to withdraw and of their right to have any information removed from the study. This

ensures that the participants are giving informed consent. Interviewees receive a copy of this form containing the researcher's contact details should any clarification be required.

Chapter Four- Interview Findings

The therapists participating in this research were recruited via the 'snowball' sampling approach as previously mentioned. In this particular study, two eligible representatives came forward and introduced the researcher to other members of the psychotherapy population who were willing to partake in the study. In total, interviews with five therapists were undertaken.

The participants are all accredited practitioners from varying professional bodies. Three interviewees' are members of IACP. One is affiliated to BACP and NAPCP. The remaining participant is a member of APPI. Professional experience in years range from: - five years for one therapist, six years for three therapists' and twelve years for the final participant. The interviewees' had a variety of work experience predominantly within the human resources and 'helping' field prior to training as a psychotherapist.

In this section, the themes emerge precisely from the responses of the participants. These themes are not pre-determined. In carrying out a comprehensive literature review that guides the researcher in the structuring of questions for the interviews, the themes that emerge here are precisely the responses of the participants'. An open and interested stance is maintained by the researcher to facilitate this emergence so as not to contaminate the findings. The researcher goes to lengths to ensure that the data arising from this study represents the true essence of what the interviewees provide her with.

It is worth noting that the researcher of this study, as a practicing psychotherapist reviews the themes that appear in this research with a humanistic and integrative eye. And so remaining faithful to the profession of the 'talking cure', the researcher has chosen to include the participants' responses verbatim so as to remain exact to the context in which each person

conveys their point of view, opinion and feelings on the matter. It is noted that when one statement is looked at in context, it may be seen that the same statement is contradicted by the same participant later on. (Bloor et al., 2002)

The themes are as follows:

- 3.1 The therapists' attitudes and beliefs about the topic of sex and sexuality
- 3.2 Client work – how the topic of sex and sexuality manifests in the therapy room
- 3.3 Managing the erotic transference

3.1 The therapist's attitudes and beliefs about the topic of sex and sexuality:

The literature clearly illustrates that the therapist's attitudes and beliefs regarding the subject of sex and sexuality are highly influential to the way he/she deals with the same said topic within the therapeutic relationship. In other words, their overall comfort or discomfort with the topic. In this particular study, the research highlights this. A combination of the interviewees' early influences in life, personal and professional experiences in addition to their chosen therapeutic disciplines all contribute to the development and maintenance of these attitudes and beliefs in one way or another. A number of the participants hinted at their early experiences in life that have been party to the shaping of these attitudes and belief.

... I was born and baptised. Religion as a Catholic had a profound effect on my own personal belief when it came to sex and sexuality because it was fear based and shame based as well.....but that didn't stop me from, fantasising about sex. you know, kind of masturbating to fantasies around having sex. Em, which again would cause a lot of shame and guilt.

I suppose it's my background em, I think what makes it easier for me. My coping mechanisms though my whole life has been to normalise. So, if there's a crisis, the best way to get me through it or me to get everyone through it is to make it really normal.

It appears that these experiences have affected the interviewee's in differing ways and that this is now part of how they both perceive the topic of sex and sexuality in the therapy room. To each of them, the topic of sex and sexuality is normal, is familiar and a part of who he/she is.

This interviewee describes how he went through a deeply profound searching in self to deal with these early experiences and the 'toxic shame' it brought up in him. This led him to a place of comfort and acceptance of himself sexually.

It's an area i've been working on for a really long time. It's a real Jungian concept, shadow process work. I can only be as comfortable as a therapist dealing with sexuality if I do my own shadow process work....Kind of challenging myself around certain areas...to be non judgemental whendealing with something shame based.

In turn, he became a psychotherapist who works predominatly with supporting clients to do the very same thing. The other participant's method of coping with what life throws out facilitates her to hear difficult things and manage them as if they are everyday occurrences. The topic of sex and sexuality doesn't faze her.

What is my opinion on discussing sexuality with my clients? Probably, that would be my main source of work as a therapist and counsellor em dealing with difficulties around sex and sexuality.....most of the people who would be coming to me with difficulties in those areas would be very ashamed.

Ok, the buildings burning. It's gonna get hot. Let's go. And clients really respond really well to that. They, clients are always battling with some rejection. I've never met a client that wasn't reacting with rejection.

However, in this following responses, this participant exudes a sense of discomfort and awkwardness about talking about sex in therapy. This leads this researcher to conclude that

this participants attitude was early formed, is solidly set and has been permeated throughout life. The other two participants do not refer to early life in their attitude formation regarding the subject of sex and sexuality at all.

It is easier to do it with a woman rather than a man.... Sometimes I feel sorry for the client. I feel like it's very intrusive.....

I think detail is intrusive....I think what you do, who touched you. That's psychosexual therapy and i'm not a psychosexualtherapist. So, I don't need to go there.....

It is very private and we have been brought up in a society where sex is something that we don't talk about. Well for me, openly.

This research indicates that four out of the five interviewee's attitudes regarding the topic of sex and sexuality has been particularly shaped through their evolving personal and professional experiences in life. Personal experiences included difficulty conceiving a child, invitro fertilisation, a family member being gay, relationship difficulties and discussing the topic of sex in their own therapy. These personal experiences seems to elicit a sense of 'ok-ness' and solidity in the therapist who has experienced this before and is familiar with the topic and the feelings it may generate in him/her.

One interviewee shared that having gone through her own experiences of invitro fertilisation and talking about her and her partners sexual functioning while going through this process facilitated her to talk with clients freely about sexual issues that may arise.

And my own fertility treatment that I had for 17 years...You know that again was being very comfortable talking about my own sexual functioning and my husband's. You know what we had to do to explore that! Again,we're talking very openly.....I wouldn't be shy about talking about sexual organs.

In the following two quotations, another interviewee eludes to how her brother being gay and her own experiences in personal therapy have impacted on her attitudes in the work as a psychotherapist and her explorations with clients then in therapy in this area. Both vignettes seem to emphasise both comfort and cumbersome areas in which this participant finds herself in with clients when discussing the topic of sex and sexuality

I learned a lot.....I suppose in sexuality through my own brother being gay and talking to him about things and what it's like for them. It's a different world. Yeah. I've been educated a lot through being in my own family. My own family reaction..... I mean its more self education and life experience.

....I think a lot of times in my experience, therapists just fire out questions. And I think sometiems that they don't have a clue about how the client feels. I know, I've been aksed questions by therapists that have been really uncomfortable and I know they put it back to me but no i just think a lot of thought has to be put into it.

In the professional sense, all the participants carry a sense of their chosen therapuetic discipline in their attitude towards the exploration of the subject of sex and sexuality in the therapeutic alliance. For some, a sense of the humanistic and integrative approach in their attitude and working approach to therapy, where the relationship is an integral part of one's work. In the other, the discipline is emphasised in being 'aloof' and the concentration on defences, transference and the conscious/unconscious material that manifests in the therapuetic encounter.

I love family therapy as well. In fact, there is a bit of a formula there.....trinagulation, childrenthey transactional analysis,who's taking on what roles. And i don't think I could do any work with couples unless I do work around sex.

If it comes up, you have to talk about it obviously. It has to be broached. But, you can't as Freud says, you can't shy away from these issues.....but em, look

you know. If it comes up, explore it but apart from that, I don't think there's a need to bring it up without being addressed by the patient themselves.'

[interviewer] *And, if it comes up? How do you feel about it coming up and discussing sexuality?*

I don't feel anything, (laughs) It's fine.....I don't take a moral standing when it comes to sexuality just because there is none. What does that mean, moral standing, traditions and all this type of thing?

In addition, it appears that many of the participant's professional experiences to date of talking about the subject of sex and sexuality with clients has facilitated them to develop and adjust their attitudes and beliefs. For others, it remains a central component of their initial training and their own belief system.

I think the more I realised what it did for a client to talk about it, the more easy it was.

I was a volunteer. 1991. I was actually employed in a sexual health clinic. We would see people pre and post test sexually transmitted infection screening, And also people who have been sexually violated. A lot of work with people who work in the industry of selling sex. Em, who were often exploited and not pain and violated in many different ways. So a wealth of experience really.

You hear all sorts. People eating faeces and you know, getting pleasure from that. It's ok because as long as you have a good bearing on you know, erotic life in infants, em and you know in our development, our psychosexual development, nothing can really shock you anymore.

It is clear that all the participants carry a belief that it is essential to be aware and to process their own particular feelings and reactions about the topic of sex and sexuality in their own therapy, in supervision and through their chosen training in order to be of benefit as a clinician. It is suggested that it is a 'responsibility' of a therapist.

When you hear a client coming in talking about fetishes, you'd be dying....But you be thinking, he's crazy and yet when you search through the research, its pretty normal. It's just that kind of stuff. And then none of us are perfect. Do I think I know myself 100%. Not a fear of it.

I think we need to get comfortable with our own sexuality and know what the boundaries are. I think you have to be very sure why you're asking the question. I stand by that you can't ask a client to talk about something that you wouldn't answer yourself.

It's to go back and reflect on our own concepts of our own experiences, our own philosophies around sex and sexuality..... if there's any judgement there, well it's not going to be therapuetic becuase you know people are very, very sensitive.....

I think the most importnat part of the training is your own analysis because you realise everyone has these thoughts. But it's knowing where they come from. Know thyself. It sounds so easy but it's not And em it's about guiding someone through that struggle.

It is plain to see that the particiapants ability to discuss, explore, challenge and to bring awareness to themselves about their attitudes and beliefs of topic of sex and sexuality is crucial in the work of a psychotherapist. It enables the therapist to decide if he or she is willing to or able to support clients to do the same. As one participant put it, the responsibility is then is to be clear and open that this is a topic that they don't work with.

...you know, not most therapists would want to work in the area of sex and sexuality. So i think maybe that's something that needs to be looked at. If somebody doesn't work in that area, they ought to state that they don't work in that area. You know?

3.2 Client work - How the topic of sex and sexuality manifests in therapy:

The topic of sex and sexuality is without a doubt a taboo subject matter in society today. It is an area that elicits a range of emotions and reactions within an individual. This research piece clearly illustrates that within therapy the topic may be brought up either by the client or

the psychotherapist in a direct or an indirect fashion. In either instance, the clinician's ability to handle this sensitively is crucial in order for any further discussions to occur.

The participants interviewed indicate that the majority of the clients present to therapy with struggles around self esteem, work, relationships and family. It is the minority that directly present with issues around the topic of sex and sexuality such as sexual abuse, sexual dysfunction, sexual relationship difficulties and sexual 'toxic shame'. Uncomfortable feelings such as embarrassment, nervousness and anxiety are commonly experienced by clients upon touching upon the subject area. The following quotes are examples of the topic coming up in therapy from the outset and during their process.

There is this feeling with one particular case. This woman felt that if she spoke about her sexuality that i would drop her as a patient...But of course that opened up so much for her.

The majority of people coming to me would be having difficulties around sex.....either individually or couples in relationships around sexual anorexia or sexual addiction. Most of the people who would be coming to me with difficulties in those areas would be very ashamed.

..usually they present like they're getting a bit embarrassed. Some have even asked would it be ok if they disuss the subject with me.

One particular client came em because of a sexual dysfunction. The doctor referred her, and her partner came with her for vaginismus. So literally, her body shut down. And the problem obviously was physical but it was so psychological.

I am thinking of one particular couple where there had been no sexual activity for 18 years. There had been no sex for 18 years and this was their first engagement in therapy. ...they didn't present with that issue. The issue was a financial one.

All participants in this research emphasise in one way or another that building a solid and trusting relationship with a client plays an enormous role in addressing the issue of sexuality in the therapy room. The theories championed by Winnicott and others place emphasis on the importance of the 'relationship' in therapy. This obviously sits extremely well within the humanistic and integrative approach. The therapist who conveys warmth, safety, boundaries, respect, healthy mirroring, humour, sensitivity, education, encouragement and understanding assists the client to talk freely. This aids a 'healing of the wounds' to ensure along with an emergence of awareness in self. The 'phrasing', timing and use of words when talking about the topic of sexuality has also been stressed as important in the way one addresses sexuality as a therapist.

I would try to create a safe environment. One of the ways I can do this is to try to get the person at ease because....all different techniques. Humour. Humour is humourising things, humanising things. It's like most people don't directly go in straight off around issues about sex and sexuality because that would be like a symptom of something maybe deeper, like shame, low self esteem.....It needs to be treated very gently, respectfully. And very sensitively....

One interviewee shared an experience of a client who came to therapy about stress anxiety in the workplace. She spoke of how this client did a 'fabulous piece of work' around her sexual identity. The interviewee described to the researcher what was present in the therapeutic encounter that allowed this client to go to that place in herself.

...she was witness to no taboos. So it's kind of like when you're in a space that you're allowed take risks. You think about risks more. You don't think of them if it's not on the table. She had always really known, didn't have a struggle with it. She just thought "I like girls but I'll end up with a guy because I want a family. My life plan fits that way." But she kind of realised that she deserved a bit more. She actually deserved to make the choice.

There is a clear and particular distinction of the therapeutic disciplines the practitioners hold at the notion of bringing up the topic of sex and sexuality with a client if it hasn't been broached before and if it appears important to their process. Predominantly, the participants stated that they would broach the topic or make reference to it in some way.

I would ask if I get the sense that there is no intimacy. I would ask how is the client in relation to intimacy? How are things in general in that area....I never to into any sort of detail. Like, they either tell me there's nothing or there's something. It depends on the client. If I've built a relationship with a client.

I have done that....because of what happened in their life experience I actually asked 'would you be clear on your feelings around what happened to you? Because you're telling me, it sounds like there's some confusion.' So that sort of initiated the piece where I asked 'and your sexuality?'

If a client hasn't brought it up and I have a feeling it needs to come up. If I can back that hypothesis up with something then I'm going to have to go there. Otherwise they're paying good money to avoid dangerous subjects then.

One of the interviewees stood out in stating that he would not bring up the topic if the client themselves didn't.

It's only really when someone is at the point where they're just about to fall over the border or step over it themselves. When they're there, it's only then can you help them across I think. I don't think anything should be brought up, particularly if something happened in the session a year ago. I don't think you should bring it up because the person is always going to return to that again. And we repeat to remember. We just have to believe in that and trust in that. Em to bring it up. Freud wrote the Dora case to show us the mistakes he made. Let's not try to make them again.

It was acknowledged by a few interviewees that it may not always be needed or appropriate to bring up the topic of sex and sexuality with some clients. It was suggested that using discretion and prudence is important in certain instances. Another interviewee stated that an example of this would be *'if it were to further the toxic shame that a client was dealing with'*. Another interviewee spoke again of timing and that sometimes the person in therapy is not ready or in the right space on certain days to talk about the topic.

....if I was unsure I would ask them. If they said no, then I would respect that. Perhaps not even probe as to why straight away. Obviously, I would take note of that and see what it was that they weren't comfortable about.

The interviewees all describe differing emotions and feelings that have come up for them when exploring the topic of sex and sexuality with clients. For the most part, managing one's feelings as a therapist is described as an inevitable part of the process when working so closely and collaboratively with clients. The handling of this varies from person to person. It can for some bring up the attitudes that were previously explored in theme one. This may interrupt the dynamic between the therapist and client and the flow of the therapy itself. For others, it is important not to allow one's feelings into the dynamic at all and keep it separate always.

I had a client before and he just was masturbating all the time and he told me. He was telling me things like everything he looks at becomes a sex object and he was having sex with his dog and everything. And actually, I just found it very uncomfortable. He couldn't walk down the street cause he was looking at girls and he was afraid. He just saw children. So that was an extreme case. And I was only starting out as a therapist. But I didn't like it and I wouldn't, it's not an area, I wouldn't want to work as a sex therapist.

The couple I have now. He's not attracted to her. She's attracted to him. She thinks he's having an affair. I'm a bit freaked because I'm thinking 'oh shit, what happens if it comes out that he is having an affair? What do I do.'

No, I don't think anything is unconstructive even if, even if you make an interpretation that obviously gets thrown back in your face, which might be resistance. You know, you can still go on. Just as long as things that are said by the analyst themselves are em ambiguous enough. So the analyst already remains aloof. That's the important part.

So the first time client's spoke crassly about sex, I remember. I can bring myself back to the room cause I was terrified, not even embarrassed. Just a bit scared about how they described it. With words that I wouldn't have used in a loving relationship.....They had a good relationship. But when you hear words...you think, hold on a fucking minute, You're not treating her right.

The interviewee's awareness of transference and its manifestation in the therapeutic setting is clear. The interviewees describe how they are alert to watching out for their own feelings as sometimes they are one hundred percent theirs and on other occasions they are the clients. The therapists' understanding of the dynamics at play and transference colours their response and attitude. It is inevitable that this may at times be even unconscious.

If I didn't want to bring something up, I'd have to look at what is going on between me and the client? If I didn't want to bring something up, usually for

me, it's because I find something gross. So I might find an uncomfortable-ness between myself and the the clients.

I remember being told there is no counter transference. I was like what? In other words, there shouldn't be.....transference is important as well as very difficult to negotiate.....The only way to really deal with it is to be in your own analysis and your own therapy because you get a sense of it.

...with transference and projections in the room, they're always battling you. So when you give them a blank canvas, they can play around with things.

3.3 Managing the erotic transference:

In this examination of the topic of sex and sexuality within the therapeutic encounter, the subject of sexual attraction / erotic transference was referred to by each participant. Erotic transference appears to warrant a specific exploration of its own. It was predominantly agreed by all that erotic transference occurs. Largely, it was referred to in the case of a client being sexually attracted to the clinician. However, the therapist's ability to have a basic appreciation of and 'love' for a client was acknowledged too.

Oh, God. I'm going to be really controversial and say that it happens. I don't think it's an issue. Em, yeah. And truthfully, I think your clients are generally attracted to you to find the answers... I think a lot of times clients will go through a stage.....where you've gone from mother to friend to future in their eyes.

Sometimes a client comes in and I go 'ooh, male energy.' And that's different. That's just nice to work with a male. I don't fancy them. It doesn't get in the way.

It was identified by one interviewee she could understand that sexual arousal and erotic transference ignites in the therapeutic setting between two people.

I think when people are sharing intimate details of their sexual desires, pleasures, activities, behaviour's, fantasies; that they can almost imagine them while they are saying it. So it may create perhaps a type of libido for them and maybe arousal even. My role as a therapist would be to measure that. So I think I would be very boundaried.

The interviewees seem to look at the management of addressing erotic transference with clients in differing ways. The approach adopted depends on how obvious the transference is; the directness of the client and its impact on the therapeutic work in the dyad. The participants spoke of dealing with it in an indirect way if it is hinted at by clients that there is an attraction there.

I had a client who told me I was really attractive. 'I'm sure you must get lots of attention when you're out'. That's not telling me he fancies me but. The way that I dealt with it was I didn't address it. I just said 'this session is about you so let's focus on you and not me'. I didn't go into 'oh that's not appropriate.' I didn't challenge if he had feelings for me cause it was said and I got an apology and there was no more.

Another participant spoke of being anxious when the client appeared to be attracted to him in her demeanor and how she actually dressed for the session. The 'seduction' wasn't addressed at this point but it was still handled and a boundary was implied.

One patient, if I remember correctly; when they walked in and they stood there staring at me rather than lying down on the couch. They told me out straight that

they wanted to look at me. And they had dressed differently that day. Obviously provocatively in an attempt to seduce me. And you know, it is just a matter of being firm, being direct and saying 'take the couch.' If you allow your own anxieties to come in, who knows what could be said.

Another interviewee spoke of 'nipping' it in the bud straight away so the position is clear and the boundary is tight in differing situations she has been involved in.

Men...when they become attracted to you, don't hide it.....'you know I thought that was great and we should go for a coffee sometime'and it's just there and then saying it really wouldn't be appropriate to go for a coffee.....and sometimes if the therapeutic relationship is strong enough it's being able to say 'I have a life outside of this'.....Just kind of clearly saying you're one hundred percent available to them here but nowhere else.

Three out of the five clinicians interviewed stated that they talk openly with their clients if erotic transferences manifest within the therapy. However, the reasons for bringing it up and their level of comfort-ability with it differed in each case.

I would bring it out in the open of course. I would approach it in the right way....I would discuss it in a way that would humorise and humanize the thing. It's very important....to be quite clear with a client that you know what has actually happened, that they might have sexual feelings for me....To avoid that question or avoid that situation would in my opinion be creating more doubt and more shame in the person I would be working with.

[interviewer] *So, it sounds like you're saying that if you're aware that there was obvious transference or erotic transference....if it was therapeutic to the relationship, you would bring it up?*

Yeah.....I would never bring my own up obviously. Never permission for that. I need to be the constant.... So if I were in a place where I was finding a client attractive, I'd just get my ass back into supervision.....Very important that the client understand that I've got my boundaries whatever about theirs. The can play around with theirs and learn but I won't.

The therapists who are quoted above respond in a comfortable manner when discussing the potential possibility of being sexually aroused by or attracted to a client. This denotes their professional experience and stance in regards to this matter. However, their individual response to the topic differs somewhat. One therapist would bring it in if they felt it was necessary and productive to the therapy process of the client and the other never would.

The language I use wouldn't be politically correct. I would use humour....and the language would have to have a huge influence on how or where I would go from there because I wouldn't be shy about using the word 'shagging.' You know, 'each other or me shagging you or you shagging me; but that's not going to happen.' You see, it's to clarify that.....I don't believe when you're dealing with something like toxic shame....it doesn't respect the political correctness.

The third participant mentioned a moment ago spoke of how she addressed a particular client's habit in session of 'scratching his testicles' and sitting in a 'suggestive and provocative manner'. She described how she left it for a few sessions before talking about it as it was interfering with their working relationship. The interviewee stated that it led to a very powerful piece of work for the client and to a deep awareness of himself.

I just wanted to talk about it and to see if he, particularly this guy was aware of it, his behaviour. And he was. He was fully aware of it. That was his life of being viewed as a sexy man and he often got what he wanted from that. So again he brought that into the therapy room.....he recognised he was a very intelligent person, aware of his own needs and what he did to get what he wanted. He

recognised that immediately when I approached the subject. Following from that, we spent a long time relating to what he done to get that response. He done that to get liked.....It was powerful actually because what he portrayed as his physical behaviour was what he was thinking and feeling.

The remaining therapists described how they would broach the topic of erotic transference if it directly impinged on the therapy leaving them in a difficult position to continue. Again, continuing or not with the said client depended on the therapist's own comfort and feelings. One of the therapists chose not to address the topic in order to let the client figure it out for themselves in the session what was going on. He states that it is only in cases where it's 'forceful' that he intervenes.

I remember one of my patients saying, 'I think about you all the time'.....I said nothing because my answer wouldn't have been enough for her. I remember she asked me 'do you feel the same?' And in that silence....she was able to sort of work out....for her there's this fella she was attracted to at work and she pretty much said to herself 'I think I'm thinking of him when I'm talking about you.' I wouldn't have been able to just make that connection.....There's still more behind that....it's only when it gets to a point where it's being forceful that you have to say 'no, that's not the way.' You invite them to look at 'what this is about for you.'

This therapist goes on to describe the feelings experienced in managing the transference in this way.

...at the time, you do feel anxious because it's new territory. And of course that the person is coming in to your space and you know, you hear stories about people trying to "jump your bones" and you're going....Jesus, I hope that doesn't happen.

The other therapist describes how she would have to end their therapeutic alliance.

...if it's coming back then to me, I don't think I could. I don't know. It's never happened but I probably wouldn't work with them if I'm honest.

It is clear from the quotes in this section that all the interviewees speak of their boundaries and the importance of holding them firmly with clients when sexual attraction and erotic transference enters into the therapy room. So too, it is apparent that being mindful of and using some of the skills and techniques referred to earlier smooth the way for the therapists to discuss such delicate and personal feelings. Words that have been used include 'clarity', 'sensitivity', 'humourising', 'humanising', 'honesty', 'gently', 'jokey', 'using immediacy', 'cushioning of it' and being 'careful not to minimise it'.

The interviewees spoke too of using their supervision as a space for each of them to process what is happening and plan out their next steps when dealing with erotic transference issues.

Yeah, in supervision. I learnt from the very beginning that is why I chose her.... Cause even in lectures in psychoanalysis, you're always talking about sexuality.....there is that sense, that understanding of sexual life. It's everywhere.

My supervisor wouldn't be as ok as I am about talking about it. So I would tailor my conversation in supervision to suit her as well. So as I get the best out of it. Because if I went in and said 'I think Joe Soap wants to have sex with me and wait until I tell you what happened,' I would spend the first half hour debriefing or breathing...

I've had three very different supervisors.... Never been a problem or an obstacle. But then they know that about me; that I come from a sexual health background. So, I'm going to bring something of that nature up.

The participants of this research study spoke about how the topic of sex and sexuality is a centre part of our lives and how this can manifest as erotic transference within the therapeutic relationship. It is clear to see that addressing the experiencing of erotic transference brings up different feelings and responses for all the participants. It is apparent that it can be a complex piece of therapy. The minority of the participants describe how they would end the therapy if a clear and persistent erotic transference came into the room. The majority spoke of dealing with it in differing ways so as to provide insight for the clients in their process.

Chapter Four – Discussion and Conclusion

From the outset, the aim in this dissertation has been to explore the topic of sexuality within the therapeutic encounter and to gain an authentic perspective into the psychotherapist's handling of sexuality within the therapy room. How do a therapist's feelings, morals, attitudes, beliefs, experiences, transferences and counter transferences impinge on the therapeutic dyad and the work?

4.1 Therapists' attitudes and beliefs about the topic of sexuality:

This study finds that the majority of the participants feel that their attitude about the topic of sexuality evolved as they professionally grew in experience. This resulted in a new awareness in self. Similarly, the interviewees describe how going through their own personal experiences of a sexual nature and working through them has shaped their awareness (e.g. issues with invitro-fertilisation, sexual dysfunction, religious influence and relationship struggles). This is in agreement with research carried out by Ford and Hendrick, (2003); Anderson, (1986); Harris & Hays, (2008) and Timm, (2009). It demonstrates that this generally facilitates a comfort and ability to discuss these issues with a client in the therapy room.

This study found that the interviewee's early developmental life shaped the attitudes they carried and some of which they continue to hold in regard to the topic of sex and sexuality. Freud, Bowlby, Fairbairn and others all clearly are in concurrence with this. One participant spoke of how his religious experiences shaped his relationship with his sexuality at one point and led him to do 'shadow process' work on himself to find healing in this area.

4.2 The management of the topic of sexuality in therapy:

The findings demonstrate that a clinician's therapeutic discipline shapes their responses and attitude towards the management of sexuality in the therapy room. One practitioner remains 'aloof' placing focus on the defences, transference and the unconscious in the therapy. Freud (1915 [1914]) was in agreement with this. However, the other practitioners speak of the importance of addressing the area of sexuality if a client hasn't done this themselves. Indeed, the premise of Carl Rogers (1980) person centred therapy is congruence, unconditional positive regard and empathy, everything that is important in a relationship. Object relations too places emphasis on the relationship. And so, the psychotherapists trained in a humanistic and psychodynamic way in this study allow their own appropriate, persistent feelings and intuition to enter into the therapy relationship enabling them to broach this difficult topic.

The solidity of relationship and timing was emphasised by all participants as crucial in this sensitive work. From a humanistic and integrative perspective, this is vital. Participants spoke of being sensitive, maintaining boundaries, being respectful, educating, encouraging and creating safety as core part of this work. Awareness of wording, using humour and humanising the situations at hand are described as a necessary part of the work in managing the subject of sex and sexuality too. Going to one's on therapy, attending supervision and talking with peers was also highlighted by the interviewees. This complements the research of Anderson (1986) and Ridley (2009).

4.3 Managing the erotic transference – willingness, ability and reluctance:

All of the participants in this study acknowledge having experienced client's being sexually attracted to them at one time or another and that erotic transference occurs. Freud (1915 [1914]) concurs. The five participants in this research spoke of having varying degrees of comfort with this type of transference ranging from avoidance to dealing with it head on. The minority choose to deal with it only if it has been pointed out by a client and if it is interrupting the work. This is how Freud proposed one dealt with erotic transference. The majority do address it and pick an opportune time to broach the transference. Only one participant stated that he does talk with a client if he finds himself attracted to him or her. He believes it has a positive impact on the therapy when handled appropriately. This falls in line with research questionnaire study carried out by Giovazolias and Davis (2001). Their study reports that 87.5% of the therapists that disclosed their sexual feelings to clients found it to be beneficial in the therapeutic process.

4.4 Education and training:

The research found that therapeutic training institutions have a significant influence on trainee clinicians, views on sexuality (Anderson, 1986; Fyfe, 1980; Ridley, 2006). This is particularly so in regard to the therapists' awareness of and formation of opinions, beliefs, attitudes and comfort levels about the important topic of sex and sexuality. It enhances the practitioner's ability to deal with the important issue of sex and sexuality within the therapeutic encounter. Self awareness, role plays and psychosexual education are cited by the studies above and by the participants in this research as being as fundamental in enabling a therapist to speak of the 'unspeakable' and to address the topic of sexuality in the counselling encounter. The interviewees speak of this as a need that they wished was met in

training, not the deficit that it was. Similarly, the participants express a hope that future up and coming practitioners are provided with this resource in training. It would appear from the research that this is a gap not being adequately addressed by the psychotherapy training institutions. It could be an interesting venture if a module of this type implemented by a training institution here in Ireland.

4.5 Limitations:

There were a number of limitations that came up while carrying out this research. The researcher found that enquiring about a practicing psychotherapist's understanding of the topic of sexuality both from a professional and personal perspective is a delicate matter. As such, it was problematic to obtain willing participants. Individuals who at the outset were willing to be interviewed were difficult and un-contactable when they were fully briefed by letter about the questions and specifics of the interview. The fact that the researcher had limited exposure and experience to this type of interviewing had certain drawbacks. In one way, the researcher didn't wish to push the interviewee into expanding upon what they were saying. As such, this may have allowed potentially enlightening material to be lost.

Additionally, due to the reflexive nature of this dissertation, i.e. that the researcher is a psychotherapist with twelve years clinical experience; a massive effort was asserted to ensure that this did not influence the direction the research took or the themes that came to light. In the interview phase of this study, the researcher incorporated the therapeutic technique of paraphrasing into the process. At times, instead of eliciting the interviewee to make statements themselves about their experiences of dealing with the topic of sexuality with

clients that could have been quoted in the research, the interviewer provided the words herself.

The researcher's own psychotherapeutic discipline is of a humanistic and integrative nature. At times, it made it difficult to comprehend, interpret and understand the theory of Psychoanalysis which is integral to this dissertation as a whole. Similarly, the researcher's awareness of this differing discipline led her to question her own analysis and interpretations of the interviewees' responses at times. For example, is a certain response a defence or is it just part of the interviewee's own discipline?

4.6 Recommendations:

The findings of this research study identify a number of gaps in research on sexuality in Ireland. There are a few studies about the effect that a core input while training as a psychotherapist has on the therapist's management of the topic of sexuality in the therapy room. A study of this kind may afford interesting results. Additionally, a comparative study based on trainee clinicians that are and are not provided with a sexuality module could prove equally revealing to the research world.

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Appendix I: Semi Structured Interview Questions

1. How many years are you practicing as a counsellor/psychotherapist?
2. What is your opinion on discussing sexuality with clients?
3. Could you tell me a little bit about your experiences of a client bringing up the topic of sex / sexuality issues in therapy?
4. How would you feel about bringing up the area of sex and sexuality with a client if they haven't broached it themselves and it seems appropriate to their process?
5. Could you envisage an occasion where you might avoid the topic of sex/ sexuality and how would you manage this?
6. What would you foresee as a reason to not bring the topic up? What do you think would be disruptive to the discussion of sex / sexuality?
7. Could you imagine a time when you may be or have been uneasy when it has been brought up by a client?
8. Retrospectively, have you ever reflected back and considered it may have been important to bring the topic up in therapy with a client?
9. Similarly, have you ever reflected back and considered it may have been unconstructive to bring the topic up in therapy with a client?
10. How would you envisage managing the therapy if you found that your client or you were sexually attracted to the other?
11. How would you deal with the transference and counter transference responses that may be elicited as a result of this?

12. Would you consider sexuality issues as a topic appropriate for supervision?
13. Did your training address sexuality at all either theoretically or experientially in preparation for client work? If so, what were the advantages to this and what was lacking?
14. If your training hasn't included sexuality, how may this have impacted on your work as a therapist to date?
15. Is there anything else you feel is important to say regarding what we have been talking about today?

Appendix II: Information Sheet & Consent Form

Dear Participant

Thank you for agreeing to participate as an interviewee regarding on the handling of issues related to sexuality within the therapy room by psychotherapists. This research is part of a thesis that is a requirement for a Masters in Psychotherapy.

This semi structured interview will be of approximately 1 hour's duration. The interviews will be recorded and then transcribed. The recordings are to be used for the purpose of this study only and will be destroyed after the project's completion.

Participation in this study is voluntary. The information contained within this sheet is yours to keep should you need to refer to it later. There is no obligation to take part in this study. If at any stage you feel you need to leave you are entitled to do so. You can also withdraw within one month of participation and request to have your data destroyed, by contacting me at the contact details below. After this period some of the data may have already been included in the write up of the thesis. The study is anonymous and no clues to your identity will appear in the thesis. Any extracts from what you say that are quoted will be entirely anonymous.

The data will be kept confidential for the duration of the study. The results will be presented in the thesis. They will be seen by my supervisor, a second marker and the external examiner. The thesis may be read by future students on the course. The study may be published in an academic journal.

At the end of the interview I will discuss with you how you found the experience and how you are feeling. I don't foresee any negative consequences for you in taking part. Approval for this research study has been obtained from the Dublin Business School Ethics Committee.

If you need any further information on the study you can contact me:

Siobhan McArdle

Mcardle.simca@hotmail.com

085 7304416

If you agree to take part in the study, please sign the consent section below.

Consent Section:

I hereby consent to partake in the research study outlined above. I understand that the information contained within this research will be used as part of the researcher's thesis.

Signed:_____

Date:_____

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