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Let's talk about sex

"A Qualitative Investigation into Obstacles Experienced by Trainee Psychologists Assessing Sexual History of a Client during the First Interview"

University of Kwazulu Natal. 2014

SUPERVISOR: Mr. Sachet. Valjee

DECLARATION

I declare that

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Acknowledgements

Thank you to my supervisor, Sachet, for collaboration and allowing me to explore. For valuing my independence and for invaluable input. For humour.

A special acknowledgement to my mother, Susan, for imparting wisdom. For challenging taken-for-granted-truths. For assuming a not-knowing stance and in so doing honouring my beliefs and encouraging personal exploration.

To my partner, Piers, for opening up possibilities. For embracing growth and change. For teaching me.

My children, Gabriel-Reece, Noa-Grace and Sebastian-Jude, for your unconditional love and patience. For expanding my horizons.

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"At the end of the eighteenth century, however, seeing consists in leaving to experience its greatest corporal opacity; the solidity, the obscurity, the density of things closed in upon themselves, have powers of truth that they owe not to light, but to the slowness of the gaze that passes over them, around them, and gradually into them, bringing them nothing more than its own light. The residence of truth in the dark centre of things is linked, paradoxically, to this sovereign power of the empirical gaze that turns their darkness into light. All light passes over into the thin flame of the eye, which now flickers around solid objects and, in so doing, establishes their place and form. Rational discourse is based less on the geometry of light than on the insistent, impenetrable density of the object, for prior to all knowledge, the source, the domain, and the boundaries of experience can be found in its dark presence. The gaze is passively linked to the primary passivity that dedicates it to the endless task of absorbing experience in its entirety, and of mastering it."

Michel Foucault

The Birth of the Clinic

Abstract

Despite adequate training and sound theoretical knowledge a trainee psychologist faces challenges whilst attempting to gather a vast amount of information from a new client. Sexual health information, although required for a full history, is often avoided due to various obstacles regarding the topic. Managing such a complex topic raises a plethora of valuable insights into current ideologies connected to the sexual health. The social constructions and meanings attached to sex and sexuality tend to highlight a need to move the trainee psychologist towards challenging taken-for-granted-truths and a more reflexive position. An exploration of emerging themes highlights age-old obstacles when managing sexual health matters.

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Aim

This study aimed to explore the obstacles faced by trainee psychologists during the first interview with a new client, specifically when taking a history, which includes information about sexual functioning and sexual history, how these obstacles impact the therapeutic alliance and disclosure as well as the strategies used by trainee psychologists to overcome these obstacles.

Methodology

This study was a qualitative study. An Interpretive Phenomenological Approach was used as the framework for this study. This approach employs a thematic analysis to first analyse the perceptions of the clinicians using the Brief Recall methodology. Secondly to further explore the meanings of such perceptions. Eleven clinicians participated in this study and were interviewed using semi-structured interviews, of which three were counselling students and seven were clinical students.

Conclusion

The results of this study showed that trainee psychologists experienced a number of obstacles during the initial interview, specifically when attempting to gather information around sexual functioning and sexual history. Such obstacles included the trainees lack of adequate understanding regarding the relevance of sexual health information and a lack of personal insight into their own meaning-making attached to the topic. Trainee psychologists adopted strategies of avoidance, haste or relying on a bio-medical framework when required to discuss sexuality in general. A valuable outcome to emerge during this study was that during the course of the semi-structured interviews with the researcher, the trainee psychologists were able to question their own belief systems in relation to the dynamics of enquiring about sexual health and its relevance to the psychological assessment of a client during the first interview. What seemed to come to the fore during the research interviews was the need to further explore sexual health not only in terms of sexual abuse as a symptom of pathology, but as a tool to build a more complete picture of the client in terms of relationships towards the self and to others. Furthermore the importance of a relational understanding of the trainee and client in relation to dominant discourses. A positive move towards deepening their own understanding of the relevance of questioning clients about sexuality and their own meanings attached to sexual health.

CHAPTER ONE

1.1. Rationale and background of the study

Training at the Professional Program at a Masters Level includes a theoretical component as well as an application component where the trainee psychologist is guided through learning the skills to conduct an intake interview with a client. The trainee psychologist is usually schooled in a structured method in which to gather information during an intake interview with a new client. This interview schedule may take the form of the Morrison Interview Schedule (Morrison, 2007) as an example. This is used as a way to guide and assist the trainee psychologist in gathering all the necessary information from the client. During the initial interview the trainee psychologist is required to gather as much personal history from the client including topics that may be sensitive for both therapist and client. This study set out to explore the obstacles faced by trainee psychologists when gathering information from a new client referred to the Centre for Applied Psychology at the University of Kwazulu Natal for therapy with a specific focus on sensitive topics such as the sexual health segment of the interview which may include sexual history and sexual functioning.

This exploratory study seeks to achieve three main objectives. These are:

- Explore the obstacles faced by the trainee psychologist when assessing sexual history and sexual functioning with a new client
- Explore how and if the obstacles affect the working alliance
- Explore how the trainee psychologists overcame the obstacles

1.2. Introduction

The trainee psychologist is informed by the training program where she is taught a specific set of skills guiding the process of conducting the first interview with a new client. This set of training skills is transferred to the trainee psychologist in the form of theoretical guidelines and role-plays to prepare the trainee for the context of the therapeutic setting. The focus is particularly on developing the skill of gathering history from a new client (Professional Program at a Masters Level at UKZN). These theoretical guidelines have core competencies which are crucial for a

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good interviewer to learn and use professionally during the first interview with a new client. According to Morrison (2007) these are:

- a. obtain the greatest amount of accurate information relevant to diagnosis and management,
- b. in the shortest period of time,
- c. consistent with creating and maintaining a good working relationship (rapport) with the client

During the initial interview the trainee is required to gather a broad range of information from the client. Included in that initial interview it is necessary to inquire around sensitive topics such as sexual history and sexual functioning of a client. Gathering this kind of information about sexual health may be complicated and affected by various factors. These factors may include gender, culture and multi-generational complexities as well as the belief systems attached to these factors which are further influenced by socio-political discourses. These issues may cause discomfort for the trainee psychologist as well as for the client. It may be assumed at postgraduate level that training has prepared the trainee psychologist to deal with all areas of the intake interview. However each individual is a construction of her biopsychosocial world encompassing age, culture and socially relevant discourses and thus she is not value free (Farnsworth & Callahan, 2013). She comes to therapy with certain ideas and beliefs about subjects and assumes a unique stance in relation to topics. In many societies and cultures, topics such as sexual health are considered to be something deeply private and not open for general discussion. The interviewing process requires the interviewer, in this case the trainee psychologist, to be able to be objective and non-judgmental and to "cast aside a lifetime of teaching, personal doubts and perhaps prejudices" (Morrison, 2007, pg 92). According to Morrison (2007) the trainee clinician may experience difficulties when attempting to gather information around sexual history. This may be due to a lack of experience or conceptual maps of how to broach just such a sensitive topic (Skovholt & Rønnestad, 2003). A vital aspect that this issue raises is that the trainee psychologist may have her own personal issues or agendas regarding sex, sexuality, sexual functioning and sexual health due to cultural or gender issues or their own personal experiences (Morrison, 2007).

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The reality is that as a trainee psychologist the task of navigating a way through new territory including: information gathering, the therapeutic context, dealing with time constraints and assimilating new knowledge and skills, may be overwhelming and provoke discomfort and task related anxiety when attempting to question around sensitive topics.

Professional organisations set out guidelines for professionals, such as psychologists and always emphasise the use of extreme caution regarding any impression of intimacy or inappropriate behavior (Yalom, 2002) . Therefore besides having to deal with personal issues of being a trainee psychologist, as well as the issues the client brings into the therapy room, added to this are the many areas that are required to be covered in a first interview including the topic of sensitive topics such as sexual health. In an overview of interviewing techniques, Morrison (2007) states that there is often a lack of gathering information around issues such as suicidal ideation, substance abuse and sexual issues. The focus of this study is to explore the obstacles the trainee psychologist experiences during this segment of the intake interview and whether training can adequately prepare the trainee psychologist for the complexities surrounding sensitive topics such as sexual history. Despite the fact that a trainee psychologist goes through a rigorous and intensive training program during the Masters training year it seems that the reality of sitting face to face with a client may be very overwhelming. Anxiety related to the task of gathering information and of being required to achieve specific outcomes such as successfully completing an initial interview with an adequate amount of information to yield a provisional diagnosis or prognosis may be heightened during this segment of the interview which is what this study seeks to explore.

Anxiety is present in most trainees whether it is around issues of performance, being observed by trainers, or their own personal inadequacy (Morrison, 2007). The training program covers many theoretical fields in order to equip the trainee with the core understanding of becoming a psychologist and using the theories of psychotherapy. The practical component of the training program serves the purpose of presenting the trainee with the opportunity to practice new found skills and assess whether competencies have been met. However no amount of role-plays or theoretical preparation can prepare a trainee fully for experiencing a client and absorbing the client's history, struggles and challenges. On an intellectual level the trainee is aware of the need

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to cover all topics during the interview, including sexual health. Yet the reality of gathering this information may be anxiety provoking which may highlight feelings of self-doubt and incompetence, further complicated by various factors such as culture and gender. This is the rationale for exploring the unique challenges trainee psychologists face during this portion of the interview and to review some of the strategies that assisted the trainees in overcoming these challenges as well as looking to the future regarding this topic.

1.3. Terminology

1.3.1. Trainee Psychologist

For the purpose of this study the *Trainee Psychologist* would be a student registered for Coursework Masters level, training in Clinical/Counselling Psychology and who is registered with the HPCSA in the above category as a Student Psychologist, or currently completing their internship in Clinical/Counselling Psychology. Throughout this paper the terms *trainee psychologist*, *therapist*, *clinician* may be used inter-changeably. At times and where relevant I have referred to *the participant*, who is a trainee psychologist, who participated in this study.

1.3.2. Sexual Health

For the purpose of this study the term sexual health will be used to denote all aspects of sexuality including sexual functioning and sexual history and sexuality. The terms sexual matters, sexual health, sexual issues, sexual functioning and sexuality may be used interchangeably. Although the term sexual health may seem to position the topic within a medical framework, this is not the intention. The usefulness of the term sexual health acts as an umbrella term to encompass the broad and complex topic in this study and to remain as succinct as possible throughout the write up.

1.3.3. Working Alliance

A description used to denote the working therapeutic relationship between the therapist and client.

1.3.4. Media

The broad term *media* is to include print, social and other forms of media.

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1.3.5. Postmodernism

A paradigm understood within the poststructuralist approach that an individual is socially constructed. This paradigm questions some of the assumptions of structuralism, that there is one truth that may be known through deep exploration and understanding. Postmodernism embraces the idea that an individual is subject to and in relation with the environment, political discourses and relationships with others and therefore each person must be viewed within their context.

1.3.6. Anxiety

Within this study, the term *anxiety* to be related to the task of gathering sexual health information during the initial interview. It denotes task specific anxiety.

1.3.7. Subjective experiences

Within this study the subjective experiences of the trainee psychologists are the primary focus. It is these subjective experiences in relation to various factors that are important and not subjective experiences viewed on an individual level.

1.3.8. Discourses

"Discourses understood to represent systematic and institutionalized ways of talking" (Madigan, 2010). Discourses as the commonly accepted ideas regarding certain topics such as gender discourses, racial discourses.

1.3.9. The use of pronouns

I have specifically chosen to use *her or she* and not the normed pronoun use of *he/she*. When referring specifically to a male participant I have used *he/him/his*.

1.3.10. Colloquial terms

I have used some terms or phrases which may be deemed as *colloquial*, such as the word *wonderful*, as an example. This was a conscious choice due to the framework of this study. The study grew with a life of its own and at times yielded the need for the use of certain terminology and to refrain from medical terms or terms I felt were too clinical.

CHAPTER TWO

2. LITERATURE REVIEW

2.1. The development of the professional

It has been well documented that the challenges of study and becoming a psychotherapist are demanding (Yalom, 2002). These demands are not only academically demanding but place pressure on the personal development of the trainee in a way that Pascual-Leone et al. (2013) describes not only as being "professional development" but encompasses the "self-development of a person". An important part of graduate training is to develop the competency of the trainee and to develop skills enabling the trainee to provide a service to a wide range of individuals. In order to develop such a large scope of competencies it is imperative that the trainee has the opportunity to explore the self, personal values and beliefs, in order to perform competently across a wide range of settings and interacting with a diverse population (Farnsworth & Callahan, 2013). The question is whether there is as much focus on the development of the personal-self as on the professional-self and whether these two aspects are suitably linked and receive equal and adequate attention during training (Pascual-Leone, Rodriguez-Rubio, & Metler, 2013). The trainee experiences performance anxiety as she is watched and examined closely by professionals in the field, such as other academics and supervisors (Rarick & Ladany, 2012). Many trainee psychologists experience issues pertaining to personal functioning challenges associated with the stress of academic expectations of graduate training programs (Rust, Raskin & Hill, 2013). Therapy sessions and interviews with clients are recorded by video and sound equipment which may heighten this experience of being observed and of needing to meet certain standards, which may be particularly difficult during the beginning stages of the training process, as cognitive maps are not yet in place to assist with these new experiences. Some of the challenges faced by trainee psychologists have been reported as self-criticism regarding their abilities as therapists, doubts about their own competencies and anxiety related to training and performance (Pascual-Leone et al. 2013). During the training process, the self-development of the person, which includes the new experiences of how to deal with people in a therapeutic context, being sensitive towards others and aware of one's own personal life and intimate relationships may not be sufficiently addressed (Pascual-Leone et al 2013). Research

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has shown that graduate trainees (those with more experience) described direct personal growth with their growth as professionals highlighting the importance of bridging these two aspects of developing the professional (Pascual-Leone et al. 2013). Part of this development of the self would include personal insights into sexuality, intimacy, beliefs around gender and multigenerational contexts as well as cultural considerations.

Farnsworth (2013, pg 206) emphasises that the trainee is able to continue to provide a service to the client despite "value-conflicts". This does not imply that the trainee will not continue to experience some discomfort in certain situations due to such conflicts in values and beliefs, rather that the discomfort should not collapse the therapeutic relationship. It should be expected that when working in close proximity with a variety of clients, the trainee should come to expect challenges to their own value system and that it is still possible to maintain a supportive stance towards the client and treatment goals despite such differences (Farnsworth & Callahan, 2013). What becomes imperative in a situation where there is a conflict in values is that the trainee is not tempted to bond with the client's presenting anguish to the same extent of the feelings of discomfort (Farnsworth & Callahan, 2013). This would result in a situation where the focus becomes the trainee's discomfort instead of the client's reason for requiring psychological assistance (Farnsworth & Callahan, 2013). A trainee must at all times be highly aware of their own values and how these will influence the way in which therapy is conducted, the implementation of treatment plans and the setting of goals (Farnsworth & Callahan, 2013). More specifically trainees need to be acutely mindful of how their own value system will dictate their proclivity to endorse a way forward for a client (Farnsworth & Callahan, 2013).

2.2. The initial interview

As a trainee psychologist, Skovholt & Rønnestad (2003) likens the experience of sitting with a client for the first time as being like a canoeist inundated by a fast flowing river and swirling through rapids in an attempt to navigate through the challenges of this first interaction. It can be overwhelming to absorb a client's story particularly for the trainee psychologist (Skovholt & Rønnestad, 2003). During the initial interview the main focus is to glean as much information as possible about a new client in order to begin building a full picture of the client's life, her personal struggles and specific needs from therapy. Information pertaining to all aspects of the

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client is helpful in building this picture. Very often the topic of sexual health is difficult to broach and there is often discomfort regarding the subject, which may be felt more acutely within the trainee psychologist. According to Morrison (2007) it takes practice to know when to ask questions during the interview process and when to direct conversation in a certain direction even when it may be uncomfortable for the client and therapist. Clients may feel the need to answer questions in socially acceptable ways and this tendency may be heightened when being questioned around sensitive topics which are either viewed as embarrassing or stigmatised in some way (Rosenbaum, Rabenhorst, Reddy, Fleming, Matthew, Howells, & Nicolette, 2006).

Part of the initial interview and the Mental Status Exam (MSE) is to make enquiries regarding vegetative symptoms such as sleep patterns, eating habits, stress levels and elimination habits. Included in these vegetative aspects are questions about sexual interest and sexual performance. This is understood, at times, to be indicative of the energy levels of a person or may act as an early warning mechanism of feelings of depression, as examples of how sexual history may be relevant (Wilkerson, 2002). The significance and importance of these questions is that sexual wellbeing is usually closely linked to an individual's sense of general wellbeing (Morrison, 2007).

Part of the challenge faced by trainee psychologists is the lack of "conceptual maps" which can be utilised by the trainee within the therapeutic setting (Skovholt & Rønnestad, 2003). During the course of training the trainee psychologist is taught basic conceptual maps, understood as general frameworks, which can be drawn on during the course of practical interactions with clients. These conceptual maps are generalised in order to cover a plethora of possible contexts when training and teaching the trainee psychologist. The reality is that when the trainee is faced with a client the context is very specific to that client and not general which heightens the inadequacies which the trainee may be feeling (Skovholt & Rønnestad, 2003). Yalom (2002) writes that it is very rare for an experienced therapist to take a detailed history from a client due to the conceptual maps having been developed and allowing the interview to unfold organically on intuition. The trainee at the point of postgraduate training, is in the process of developing a suitable repertoire of conceptual maps from which to draw on add actual experience with clients,

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may be limited resulting in the need to follow a structure such as the Morrison interview schedule during the initial interview process.

To assist with this quandary of theoretical training and perhaps limited experiential learning, the trainee psychologist is taught to follow a systematic checklist of inquiry to cover all necessary topics until the initial intake interview becomes more familiar and anxiety in the trainee therapist diminishes. The interview schedule is thus an attempt at being able to contain anxiety and gather information. It leaves the trainee at a juncture of attempting to cover the basics in a relaxed and confident way, while gathering all the required information according to a schedule. The topic of sexual history and sexual functioning may intensify anxiety around the first interview. Morrison (2007) isolates certain subjects and classifies them as being "sensitive subjects". These include subjects such as violence, suicidal behavior, substance use, homicidal thoughts and ideas, sexual abuse and sexual life which includes sexual practices and preferences (Morrison, 2007). These subjects are required to be covered by the trainee psychologist and if the client does not raise these topics of their own volition, the trainee psychologist is compelled to raise them herself (McGregor, 2010). Reporting or recounting one's sexual behavior in a one-on-one interview may prove difficult and embarrassing for a client and may cause a certain measure of concealment of their sexual history, preferences and practices (Gribble, Miller, Heather, & Rogers, 1999). However it does seem vital to learn the skill of asking questions in particular ways as it must be remembered the influence the therapist, albeit the trainee therapist, may have on the therapy process (Morgan, 2002). Morgan (2002) highlights the unique relationship between therapist and client and the interaction between the two referred to as a "consultative stance". Although people do not necessarily come to therapy for body troubles, questions about sexuality or struggles with sexual health on a conscious level, it seems that whatever the emotional predicaments are of the person, the body is always somehow wrapped into the complete picture and functioning of the person (Orbach, 2009).

2.2.1. Taking sexual history

Although there is theoretical training on subjects such as Suicidality, drug and alcohol use there appears to be limited training in sexual health in most graduate programs (Macdowall, Parker, Nanchahal, Ford, Lowbury, Robinson, Sherrard, Martins, Fasey, Wellings, 2010). The topic of

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sexual health is complex and Brandenberg (2009) writes that the key issues in taking a sexual history are:

Sexuality is a subjective, internal experience

Ideas and agendas of sexuality are unique to individuals

Sexuality is closely linked to intense emotions, self-image and self-consciousness

Sexual health is not the absence of sexual problems

Sexual health is more related to the capacity to respond to problems and changes

Keep in mind that most men and women will have sexual problems at some stage in their lives.

The World Association of Sexual Health mission is to " achieve a better world through ensuring sexual health for all" (Markovic, 2013, p. 311).

2.3. The Working Alliance

A vital part of the first interview process is the emerging working alliance between therapist and client, which is defined in terms of how the client and therapist are able to establish good rapport and the ability to work together. The working alliance is essential in order for the client to feel safe, secure and contained in a way that it becomes possible to disclose her personal history within the first session. It is important for the clinician to create a context of warm positive regard for the client and maintain an attitude of non-judgment and acceptance in order for the working alliance to develop successfully (Morrison, 2007). Most people require information about the therapeutic process and the therapeutic relationship as well as an idea regarding the expectations for therapy which highlights the necessity of orienting the client to new experiences and the information gathering method in order to create a sense of safety and comfort (McWilliams, 2004). According to McWilliams (2004), the more a therapist is able to share, orientate and educate a client the less likely the client is to feel threatened or guarded. If the therapist is able to be plainspoken about the process and the purpose of history-gathering, in a way that may impart knowledge and potentially promote personal insight, the working alliance may only be strengthened. By hiding behind a sense of mystery and with no clear reasoning explaining the purpose of gathering information, the less likely the client will invest fully in the process of therapy and commit in an honest and open manner (McWilliams, 2004).

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As the working alliance emerges it is important to nurture a transparent agenda regardless of the topic being discussed, including aspects relating to sexual health. Buehler (2014) highlights that culture and the profession of psychology have "maintained the secrecy about the emotional and psychological aspects of sexuality". This structure perpetuates the cycle that topics such as sexuality and sexual health are kept hidden and secret, and in doing so this discourages conversations of sexuality which results in a lack of opportunity to develop broader understandings around these matters (Buehler, 2014). The more the therapist can model tolerance and acceptance at times when the client is able to express and delve into topics of discomfort or sensitive topics, the more the client will feel safe to continue which will further strengthen the working alliance (McWilliams, 2004). Some critics have argued that theory and research training methods are outdated, however mounting research indicates that therapists who seem to have good outcomes with their clients, are those who are able to "embody certain personal qualities" such as transparent communication, and in some way use this as part of the therapeutic process, as the therapist being viewed as the tool (Pascual-Leone et al. 2013). This draws attention to the need for personal insight to enrich understanding of the self in order to develop a working alliance with the client and manage feelings of discomfort and incongruent values between client and therapist.

2.4. Sexuality

2.4.1. Human sexuality and wellness

Sexuality is richly social and encumbered with numerous meanings which are complex and multilayered (Plummer, 2010). Human sexuality has been debated in many forms and can be viewed within a myriad of contexts. Over time great thinkers and intellectual approaches to understanding society have called for taking into consideration precisely where sexuality fits within society's confines and norms, as well as the origins of certain ideas about human sexuality (Smith, 1999). At times there may appear to be fixed norms yet there are also constantly new norms emerging and evolving (Plummer, 2010). Elias (1969), an influential writer of the esteemed book, *The Civilizing Process*, posits that this process occurs through dynamic, social networks, relationships such as families and work-related groups, and writes that our ideas are formed through this interactive process. At the time of writing his book, Elias was acutely

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influenced by Freudian psychology and society at the time which espoused the enculturation of restraint, shame and disgust, specifically around pleasure and human sexuality (Smith, 1999). Elias argues that over time the ideas of civility and decorum were measured by the mechanism of self-restraint and of "refined forms of individual behaviour" and the bar was set particularly high regarding the capacity of applying self-discipline regarding the natural functions of the human body (Smith, 1999). Foucault (1984) puts forward the argument that in the old world, such as the early Greek and Roman civilisations, that if one had good judgment then it was deemed possible that both pleasure and control could be balanced in life by drawing on the relevant knowledge about the body, medicines and diet, as equal examples. Despite the variations in norms and changing sentiments the key to understanding human sexuality is that the identities of humans rely on others and as others and society changes so does the self and the sexual identity of the self and sexual norms. This is important as Plummer (2010) indicates, that throughout the history of mankind, sexuality is an inherent part of the human psyche and cannot be ignored due to the intricate connections to others. For this reason the question of sexual health is another facet of an individual that adds information to expand the understanding of a person as a whole. The importance of gathering information pertaining to an individual's sexual health is that it may be indicative of how healthy an individual's lifestyle is (Chestnut, 2008).

Sexual health may be defined in many ways. According to Chestnut (2008) sexual health includes concepts such as relating to human reproduction, disease prevention, sexual pleasure and relationships. Sexuality is a critical way of giving and receiving pleasure for the self and to be able to give to the other. Sexuality is a means of interpersonal connecting, personal efficacy and an individual's acceptance of her own body and self (Wilkerson, 2002). Research has shown that there is a correlation between sexual health and general wellness which includes concepts such as nutrition, physical fitness, work satisfaction and spirituality (Chestnut, 2008). As stated, human beings are constantly in relation to one another and often these relations are sexual. It would seem that sex, and by default the topic of sexual health, plays a significant role in the lives of most people, yet it is a topic that is still found to be taboo and not openly discussed, despite it being part of many people's lives as well as intricately wrapped up and connected to personal identity. Although sexuality was always considered and consciously perceived as a natural force and function of humanity, political structures, changing social

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networks and a plethora of influences have resulted in peoples' perception of how the rules regarding the body and sex have changed over the course of time (Smith, 1999). As certain religious beliefs spread throughout the world there was a shift from traditional beliefs about the body and pleasure, towards a view that the self was the site for ethical work or as the project, with a focus on fearing the body as a source of temptation and sinfulness and these taboos reverberate throughout the psyche of the human (Foucault, 1980). These complexities highlight the rich diversity in beliefs over time which should propel one to consider human sexuality more and indeed not less.

2.4.2. The relevance of sexual health information

The importance of obtaining an overall picture of a client is central to understanding, as best as possible, the client within her context. This includes having a contextual understanding of the wider social, cultural and political discourses of the time. Morrison (2007) outlines some of the areas highlighting the importance regarding enquiries about sexual health:

- To be alerted to Sexually Transmitted Diseases
- Paraphilias
- Common sexual issues such as *impotence* and *dysparenia*
- Sexual practices
- Sexual preferences
- Sexual abuse - current or past
- General well being
- Ability to connect with others
- Insight into intimate relationships

It has been shown that there is a link between childhood sexual experiences and adult mental health difficulties such as *Borderline Personality Disorder* and *Anorexia*, *Post Traumatic Stress Disorder*, *Relational Problems*, issues with *self esteem* and *self image* in relation to *Mood Disorders*; and too often this line of questioning is overlooked by mental health care practitioners (Morrison, 2007). According to Perel (2007), when working with couples, the sexual relationship can often be viewed as a metaphor for a couple's overall functioning. Chestnut (2008) claims that sexual health must be seen as a genuine measure of wellness.

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Morrison (2007) writes that a loss of interest in sexuality may often be seen as an early indicator of mental illness. Therefore relevant questioning concerning the topic of sexual health would focus on concepts such as: when changes in ability occurred, cognitions or feelings about sexuality changed, the direction of the change either a loss of interest or heightened interest as well as physical and emotional ability to find enjoyment in sex (Morrison, 2007). This type of enquiry begins to position the topic of sexual health within a medical framework. There is another aspect to sexual health that seems to be overlooked not only by the general population but by professionals and this is the importance that the sensation of sexual experiences can generally enhance wellbeing in some instances in the same way that physical exertion in the form of exercise may be highly beneficial to people (Orbach, 2009). These thoughts around the positive benefits of sex and better understanding of sexuality may make one feel uncomfortable, especially if a vocabulary for sexual health has not been developed yet vital in bringing into the discussion (Perel, 2007). Perel (2007) and Orbach (2009) both indicate the relevance and intricacies of broadening the possibilities of sexual health information and the need to be inclusive of the view of all aspects of the individual.

Orbach (2009) advocates how the physical body is part of who we are and unique to our makeup as individuals as well as being distinctive of the way in which an individual expresses herself. The body and ideas around sexuality are nuanced expression of one's culture, the religious and specific period in which the individual lives and therefore has the ability to offer rich information about a person's internal life and experiences (Orbach, 2009). Overall health has been positively correlated with having good self-esteem, being able to engage with a partner on an intimate level and having a positive attitude towards sex and sexuality (Rheume & Mitty, 2008). However the understanding of sexual health predominantly orbits around symptoms and pathology. Perhaps more importantly than the significance of looking for symptoms and pathology, is to understand a person as part of a complex biopsychosocial context and this includes: physical processes, psychological processes and social processes (Brandenburg & Bitzer, 2009). Sexuality covers all three of these spheres indicating the importance to an overview of sexual wellbeing and sexual health along with all the other facets of a person. This is important as disturbances in one level of functioning will impact another area of functioning, compelling the need for an overall view of the person (Brandenburg & Bitzer, 2009).

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Furthermore research shows that within the medical field of dealing with HIV patients, that silence around sexual issues galvanises the power relationships between the professional and the client (Villaamil, 2014). The reason for this is that there is a powerful "biomedical" narrative around sexual issues of the professional directing and defining what will and will not be discussed in an interview as well as the professional being the expert and therefore her authority is not questioned (Villaamil, 2014). The result is that the power ratio set in motion due to this narrative defines the scope of knowledge and visibility regarding sexuality (Villaamil, 2014). When questions regarding the topic of sex and sexuality are reduced to a function, the risk is that dysfunction is implied by default (Perel, 2007). As science and the medical model predominate, the focus on sexuality loses its vast breadth and rich amount of information that is included within a person as a whole. When questions focus on: How often? How much?, the risk is a superfluous view of a person and the loss of a far larger description of a person and their beliefs. This loss is the lack of understanding the erotic, the relationships, the connections and the ideas of body image of a person (Perel, 2007). What is neglected is the art of connecting and the ability to do so with intimate partners as the focus is purely on the mechanics of the act and a mechanistic view of sexual health, a medical positioning perpetuates this understanding.

Since the 1970's, during the sexual revolution it appeared as if there was a strong move towards developing a more accurate vocabulary for sex and sexual health (Orbach, 2009). Despite the fact that school curriculums now teach sexual hygiene the lack of confidence in understanding and talking about sexual health with purposeful understanding seems to be at an ebb (Orbach, 2009). An example of the complexity of this issue is how school sex-education teaches girls how to put a condom on a partner yet completely disregards any education on understanding and enjoying their own bodies which feeds the biomedical framework and narratives around sex (Orbach, 2009). The complexity of this issue is that on a medical and scientific level one can view progress in a better understanding of symptoms, illness, protection and disease yet there is a lack of being able to engage with the topic of sex and sexuality without causing discomfort or anxiety for many (Perel, 2007).

At times it may not seem obvious to the therapist to take note of the body and human sexuality as often routine practices, beliefs and views of the physical body may be taken for granted and

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therefore disregarded. However by incorporating a more thoughtful approach to the body and sexuality it promotes a deeper and richer view of the person (Orbach, 2009). Research is focusing more on the psychology of bodies, functions and behaviours in order to be able to better understand the psychosomatic theory of human development (Orbach, 2009). It becomes imperative to be able to bring conversations about sexual health and bodies into therapy in order to be inclusive and mindful of all aspects of a person's functioning and not to avoid aspects that make one as a trainee psychologist feel uncomfortable.

2.5. Gender complexities

2.5.1. Gender and the individual's context

The trainee psychologist is faced with a multitude of variables in terms of gender complexities. The diversity of population groups and the variations of family and relationship structures result in endless possibilities to grapple with, within the therapeutic setting. It is generally accepted in most fields that there are various differences between gender. Traditionally boy children are raised to be *warriors* and girl children are encouraged to be *demur*, sit quietly with their legs crossed (Orbach, 2009). Physically and biologically the evidence is clear, however the differences on a psychological and emotional level are slightly more difficult to pin-point. Literature posits that sexual psychology and behaviour differences between the genders are present, however the research seems to be mostly supported by emotional evidence rather than scientific evidence (Okami & Shackelford, 2001). Culturally boys and girls bodies are taught to be appropriately expressive without any explicit teaching and without these ideas or norms being questioned (Orbach, 2009). Research drawing on modern Darwinian Theory, neuroendocrinology, human genetics and social and behavioral sciences strive to illustrate gender differences (Okami & Shackelford, 2001). However gender differences are complex and difficult to define. Subtle differences felt within the therapy context may be more difficult to describe due to the many factors which may be involved such as feminism, power imbalances, patriarchal systems, personal issues of the trainee as well as cultural norms (Tseng, 2005). Men and women are influenced by the relationship structures held within their culture and this must be considered (Tamasese, 2001).

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Adding to the complexity of gender is that not only do men and women seem to live in two very different sexual worlds but that each gender has developed sexual psychologies that have evolved and adapted to these different worlds (Okami & Shackelford, 2001). Research conducted by Tamasese (2001) describes how women from subjugated cultures have tried to point out that gender and culture cannot be separated, furthermore that the ways of living as a woman or as a man are always influenced by the symbolic representations and rituals attached to any given culture. The consequences are far reaching as each gender will define and understand a variety of concepts such as sexual drive, sexual interest, partner preference and partner variety in different terms. These terms are defined by that culture at a specific juncture in history. The trainee psychologist is faced with an array of possible gender disparities either of her own making, intricately attached to her personal issues or those linked to social structures and current discourses. When talking about gender, cultural considerations and a certain measure of awareness is important, however so are the implications of factors such as class and sexuality and that this complicates the ease at which one attempts to compartmentalise topics (Tamasese, 2001). There is a need for trainees to increase self-awareness pertaining to gender stereotypes and how these may influence her ability to work with clients and to recognise that there are various ways in which an individual may express himself or herself across different cultures (Rarick & Ladany, 2012).

2.5.1. Gender differences in a therapeutic context

The trainee may not have developed her own sense of self in terms of gender and sex-roles nor have questioned and explored how gender complexities may cause discomfort for client or therapist. Gender roles, traits, attributes and stereotypes are deeply ingrained in society (Pease, 1997). Despite this it is assumed that at the level of postgraduate training that any rigidly held beliefs would have been diluted. In research conducted by Greenberg and Zeldow (1980), female graduate students indicated the preference for a male therapist with a more traditionally defined persona which fit a typical sex-role stereotype and that men indicated their preference for a psychotherapist that fitted with a stereotypical female sex-role traits (DeGeorge, Constantino, Greenberg, Swift, & Smith-Hansen, 2013). More recent research conducted by DeGeorge et al. (2013) found similar results indicating that gender roles and the expectations of these roles are strongly affected or dictated by the gender of therapist and client. Despite many changes in

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gender-role stereotyping in the last three decades and the shift towards more equitable job creation, there remains a tendency to have preferences for a therapist hinging on traditional gender qualities (DeGeorge et al. 2013). Most significantly women expect a male therapist to possess traits of dominance and autonomy which are traditionally attributes linked to masculinity and the male gender role stereotype, and a male client expects the traits of abasement and the seeking out of affectionate care and social support, perpetuating ideas of female submissiveness and obedience (DeGeorge et al. 2013). A salient point to emerge from the research by DeGeorge et al. (2013) is that the majority of participants preferred to have a female therapist and although male clients were content to have either male or female therapist, the majority of women were unequivocal on the preference of a female therapist (DeGeorge et al. 2013). In order for the therapist to be unaffected by the expectations of a client it is required that she is aware of such ideas regarding stereotypical roles, expectations and qualities linked to each gender, and that therapy is conducted without perpetuating such beliefs. The therapist is required to be closely attuned to her client without perpetuating entrenched beliefs and playing out roles the client may have come to expect (McWilliams, 2004). This highlights the crucial requirement that the trainee psychologist has personal insight into the complexities of gender within the therapeutic setting.

2.6. Socio-political discourses

In order to understand the individual the trainee psychologist must understand herself within her own socio-political context as well as the context of the client. Individuals are encumbered by discourses and although discourses may change over time, some remain deeply embedded within society, one such discourse being *patriarchy*. There are many socio-political discourses which may be included, however, for the scope of this study the focus is on patriarchy and feminism due to the relevance in relation to the discussion and emerging themes.

2.6.1. Patriarchy and Feminism

Social meanings are deeply entrenched in society and are shaped by both personal experiences as well as by historical contexts (Plummer, 2010). The stories people tell about their lives and engage with are done so in a way that gives meaning to their experiences and these internalised ideas and thoughts are shaped by culture (White & Epston, 1990). The way in which people

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engage with others and build relationships as well as the way in which they view others is shaped by these internalised ideas, which in turn have been shaped by culture, by society (Nylund, 2006). This can be better understood if one looks at Foucault's writings on discourses found in society and cultures as being a system of words, actions, beliefs, rules and institutions that share universal values. Particular discourses maintain dominant and powerful worldviews (Nylund, 2006). A discourse such as *patriarchy* is maintained through the use of particular words, beliefs, rules, ideas and institutions that will keep this certain discourse, or ideas alive within a culture and society. Okami (2001) describes patriarchy as being a particular type of social arrangement whereby males occupy most societies upper positions. These positions can be either in a political arena as well as within the realm of all social arenas. Within a patriarchal system the hierarchies outside of the family setting are found to be universal within all spheres of life (Goldberg, 1993). Added to this is that there is strong evidence that this societal structure does not seem to have ever been any different nor have much potential of changing (Goldberg, 1993).

The pervasiveness of dominant gender ideologies tend to subscribe to the view of what is termed "hegemonic masculinity", meaning males fulfilling and subscribing to the male roles traditionally assigned to them: fighter, aggressor, protector, breadwinner (Nylund, 2006, p. 159). A feature of traditional ideas of manhood and masculinity is that the role of women is to take on the greater portion of the parenting duties with the children, as an example (Nylund, 2006). Scholars of gender, Brod and Kimmel, have described at least five distinctive features of hegemonic masculinity which may reinforce patriarchy discourses, as found in the United States of American culture: physical force, occupational achievement, patriarchy, and heterosexuality (Brod, 1987). The implication of a patriarchal society is that there are far reaching consequences and repercussions affecting the many aspects of sexual relationships as well as conversations between men and women. It has been posited by some that the very belief of shame in terms of sexuality are dictated by patriarchal discourses within society and have a pervasive impact on the psyche (Pease, 1997). There is a wide commentary on the fact that there appears to be a rise in the display of stereotypical masculinity found in the modern era (Orbach, 2009). In the past men and women used their bodies as the tools for their physical work in order to run the households; such as chopping wood for the fire, riding or walking to work, carrying heavy goods (Elias, 1969). As the world has modernised so there has been less physical exertion of the body as there

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has been less need for it as technology does more for humankind. This change may bring to the fore that bodies are used less physically, and the predicament is that it is difficult to find new functions and purposes for bodies, perhaps causing frustration and disharmony for many people and a need to retain patriarchal views (Orbach, 2009). An awareness of this kind of new conundrum is imperative for the health care worker to consider. Idealised forms of masculinity have been found to limit men's ability to connect to others as well as having a restrictive effect on a man being able to express himself emotionally (Nylund, 2006). It has been argued by Katz (1999) that the media plays a pivotal role in perpetuating and recycling some of the above mentioned attitudes about masculinity and by default, patriarchy, that images have a "primary influence on reinforcing hegemonic masculinity". Historically women bodies have been defined in accordance to a male dominated discourse and reinforced by societies structures and institutions. Women's intellect and sexuality has mostly been separated and femininity associated with purity, sacrifice and dependence on others, mostly dependence on men, to care for and make decisions (Perel, 2007). In contrast to the *pure woman* is *woman* who embraces her sexuality and finds herself criticised and judged and this patriarchal spilt between lust and virtue is apparent even in the 21st century (Perel, 2007). These ideas of virtue, purity and goodness are subliminally present in the social world and commonly held beliefs relating to gender.

The trainee psychologist is required to be aware of her own culture, patriarchal discourses and the expression, or lack of expression of female sexuality. These inherent issues come into the therapy room with both the client and the therapist: their differing views on gender roles, expectations and personal experiences of gender as they are influenced by socio-political discourses.

2.7. Cultural considerations

Although the trainee psychologist is socially constructed, cultural construction of the psyche is a further consideration. The term *culture* is different from *race*, *ethnicity* and *minority* although in many instances these concepts are used interchangeably which is incorrect (Tseng, 2005). For the purposes of this study it must be clarified that *culture* is to be understood as referring to behaviour patterns as well as value systems which individuals with a specific group may share.

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Culture is learned through a process of enculturation which begins in early childhood and continues throughout life shaping integrated and patterned systems of values and beliefs of a group (Tseng, 2005). The ideas and beliefs about bodies and sexuality are formed by the earliest encounters with caregivers and social structures as well as the cultural prescriptions and imperatives which place injunctions on how the body should appear and behave in order for the individual to be deemed accepted as part of that cultural group (Orbach, 2009). The value systems of a culture are passed on from one generation to the next in the form of symbols and words, and is part of an intricate verbal and non-verbal scheme, a creative and active system (Tseng, 2005). Cultural taboos about subjects such as erotic fantasy may be so strong that for many individuals the mere mention of such a topic can provoke deep feelings of shame and anxiety (Perel, 2007). According to Morrison (2007) all persons use circumlocutions on a daily basis in order to avoid seeming vulgar utterances or offending others and states that within "polite society" this is a common practice. Within each culture these circumlocutions will differ and require an individual to adhere to the rules of society and language especially when it comes to discussing sensitive topics such as sexual history and sexual functioning. As an example the phrase "sleeping with" is often used to indicate "having sexual relations with" (Morrison, 2007, p. 54). Cultural awareness would be crucial to understand the nuances of these circumlocutions which are deeply embedded in all cultures and will differ from one culture to another. The process of therapy therefore calls for communicating in culturally relevant ways which is enhanced by establishing a good working alliance with the client. It also calls for a broader perspective when working with diverse cultural groups. It is vital to understand the need to constantly reassess and become flexible in choosing suitable goals, techniques and frameworks according to personal values as well as meeting the needs of the client (Tseng, 2005).

Culturally-responsive health care has been defined as dignifying and responding to cultural differences and requires that health service providers deliver adequately for all cultural groups (Mirsu-Paun, A., Tucker, C. M., Herman, K. C., & Hernandez, 2010). In order for psychotherapy to be relevant it requires the clinician to be able to respond and manage clients while acknowledging and respecting the multiple levels which culture encompasses (Tseng, 2005). The concept of being *culturally sensitive* focuses on the ability of a clinician to have the capacity to meet the needs of all cultural groups by being able to adjust one's perceptions to both

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behaviour as well as to be able to practice different styles of service provision to meet the required needs (Mirsu-Paun et al. 2010). Being culturally sensitive requires a therapist to have the capacity to explore and find knowledge around certain cultures in order to expand the understanding of a client (Orbach, 2009). Added to this already complex issue of sexuality and culture is the fact that there seems to be an overwhelming ambivalence around sexuality, predominantly in the western culture. According to Perel (2007): "while we recognize the importance of sex we none the less vacillate between the extremes of excessive license and repressive tactics". The trainee psychologist is faced, within the intake interview with a new client, this multitude of concepts, issues and diversity which somehow needs to be absorbed, assimilated and then dealt with in a professional and efficient manner.

2.8. The influence of age

Although sexuality is an important facet of being human, the roles, beliefs, facts and fantasies vary from person to person and specifically from one generation to another. The reason for this is that people find themselves within a biopsychosocial world which means that an individual is influenced by religious, economic, cultural and spiritual aspects (Rheaume & Mitty, 2008). The variation of these influences can be great and the therapist must be aware of the fact that each generation is influenced by a different set of economic problems, different religious debates, different cultural considerations (Rheaume & Mitty, 2008). At certain ages there appear to be certain expectations and behaviours deemed appropriate or inappropriate, mediated by age. Societies are organized on multiple layers and a key difference in all societies is delineated by age (Plummer, 2010). It may be assumed that these differences hinge on the obvious differences such as the biological differences, for example, between an infant and an elderly person. However generational differences are far more complex and more pertinent than purely being isolated to biological processes. Plummer (2010) posits that the stratification of age generates many behaviours and beliefs as well as social expectations that are galvanized within each age group. Furthermore age appears to dictate which conversations are found to be permissible and who may discuss sensitive topics or ask sensitive questions particularly around the topic of sexual health (Tutani & Rankin, 2000). These social expectations and role expectations solidify in generational gaps as one cohort creates inter-generational narratives (Plummer, 2010).

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There are widespread cultural variations regarding age. The norms for child rearing and how infancy, childhood and adolescence are described and understood may differ from culture to culture. In some cultures the elder generations are held in high esteem yet in others the elderly are seen as having little value in society. Younger generations are supported by family and the community for longer periods of time in some cultures while in other cultures the youth are expected to become self-sufficient at earlier ages (Plummer, 2010). Due to these differences between generations it is often found for example, that adolescents may mistrust older people and this may be a challenge within therapy (Morrison, 2007). In addition it is vital to be aware of the language differences between generations. Sexual talk and slang, or the word Morrison uses, the "circumlocutions", in one generation may not be understood by another generation (Morrison, 2007, p. 54). The very sexual embodiment of one generation may differ overwhelmingly between age groups and these differences are manifest in what is viewed to be appealing, acceptable and attractive (Plummer, 2010). The trainee psychologist is confronted by a range of varying age clients and each client will require a different approach due to her generation and attachments or associations linked to issues around sexual health. Socio-political awareness is relevant in order to further explore the underlying factors that influence a particular cohort and differentiate one generation from another. Currently older adults who are now in the 70's and 80's age group were preoccupied with the raising of children and meeting the daily challenges of life during the time of the sexual revolution (Rheume & Mitty, 2008). The significance of this is that this generation may be unschooled and unfamiliar with some of the more liberated views of the modern era around sexuality. The historical context of each generation dictates concepts of sexuality and intimacy, how these are expressed, as well as ideals of body image which may create several obstacles linked to discussions of sexuality (Rheume & Mitty, 2008).

It is important to challenge assumptions about aging and sexuality and become familiar with current efforts to understand sexuality as part of the lifespan of all people (Rheume & Mitty, 2008). Research has shown that sexual desire only begins to diminish from the age of 75 which highlights the importance of including sexuality as part of the complete understanding of the functioning of an individual (Rheume & Mitty, 2008). The trainee psychologist is required to be mindful of dealing with sexual matters delicately bearing in mind that sexual health should

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consider sexuality more broadly than what is portrayed in the media, as older adults do not necessarily equate sexuality with intercourse but rather understood as a need to connect and the sensation of feeling loved as part of their sexual identity (Rheaume & Mitty, 2008). Within the therapeutic setting professionals may be influenced by the dominant cultural assumptions that older men and women are not seen as sexual beings and may also be products themselves of stereotypical myths about sex during the aging years (Rheaume & Mitty, 2008). The trainee psychologist is required to be able to meet the client at an appropriate level of communication for there to be mutual understanding. Language, terminology and phrasing becomes paramount when client and trainee psychologist are working together.

2.9. The impact of the media

Many gender stereotypes, cultural beliefs, ideas about aging and socio-political discourses are portrayed and entrenched through the various modes of modern day media. There has been a long standing debate regarding the affect of the media on the psyche. Several experts claim that the media perpetuates and naturalises traditional gender roles and violent behaviour (Nylund , 2008). Western culture which seems to be the dominant global culture, places emphasis on the importance of youth, beauty, vigour and physical attractiveness (Rheaume & Mitty, 2008). The implicit message is that aging and sexuality are therefore binary opposites as the media inundates us with the drive to retain a youthful appearance which fuels the idea that older adults do not have a sexual identity (Rheaume & Mitty, 2008). Globalisation has created an environment where as citizens of the world we are hard pressed to escape the multi-media influences around us every day. It is near impossible to avoid the influence of the mass media and its influence. The availability and sheer volume of multi-media platforms has made both image and product of the media available to almost all people on the planet, even those of modest incomes, and media stretches to all corners of the earth (Nylund , 2008). According to a publication by Monk cited in Nylund (2008), he writes that popular culture and the media culture has gained hegemonic status becoming one of the most powerful forces currently shaping the cultural identity of the modern era .

Added to this is that currently there seems to be a paradox to the modern era. Sex and the albeit subtle use of sexuality, is used to sell everything from products to lifestyle and the gratuitous

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images of sex and sexuality are difficult to escape whether depicted or implied in advertisements or in movies, yet society has not kept up with challenging the stereotyped portrayal of gender roles, sexuality, love and lifestyle . On the one side of a coin the media flood the populace with images of how the sexually attractive body is defined and on the other side of the same coin is the firm belief in having a chaste body (Orbach, 2009). The images and innuendo of sex and sexuality are in every facet of modern day living yet it remains a difficult topic to discuss. The contradictions of sexuality are difficult to navigate through as physically the external body is viewed as a sexual landscape and this is reinforced in the media and at the same time modern man appears to be losing connecting with a language about sex and emotions, desire and eroticism (Orbach, 2009).

Consumer -society has sold the average person into the belief that the use of the sexualised body can represent and sell the picture of how life should look (Orbach, 2009). The result of this powerful force in the modern world is that people style and mould a large portion of their identities on much of what is portrayed through various modes of media (Nylund , 2008). However there appears to be no balance in this discourse, and a heightening of this disconnect between a focus on the physical, sexual being and the profound lack of a vocabulary to articulate discourses around sexual health (Perel, 2007). What permeates into the very core of all cultures is an influence on individuals about performances of identities, relationships and expectations of others as well as the shaping of relationships. These can include ideas about gender, race, nationality, class, sexuality and ethnicity and it becomes difficult to separate oneself from these messages and symbols produced by the media (Nylund , 2008). Society and the wider global culture becomes more and more compulsively sexualised it loses the organic nature of the act itself and the value of the act, and in connection with another which seems to result in a general experience of sexuality becoming a place of confusion and disappointment (Orbach, 2009). Perhaps the most important quote pertinent to this topic is: "cultural studies show that media culture articulates dominant cultural identities" (Nylund , 2008, p. 6). Not only are cultural ideas stereotyped within the mass media, so too are ideas about gender, age and various socio-political discourses which influence the values and beliefs of individuals. These ideas become accepted as truths and remain unquestioned or closely examined.

2.10. A post modern view

Social constructionist thought is driving the postmodern era and is moving the world considerably more towards an understanding that there are more than one realities (Markovic, 2013). It is a move away from the emphasis on the process of individuation which means that an individual constructs her own internal world on her own (Dulwich Centre Publications, 1999). The postmodern view positions the individual within her context where she interacts on various levels within society and through those interactions she creates meaning. Thus an individual is said to be socially constructed (Dulwich Centre Publications, 1999). Hence the salient feature of this postmodern paradigm is that each individual will engage and interpret reality according to a personal view of the world which is shaped by unique and personal experiences and relationships (Madigan, 2010). Hence reality is viewed as being in a state of constant flux, of being constructed, deconstructed and reconstructed through the use of language and the interactions between people (Markovic, 2013). Personal values are so diverse, from one individual to another, that very often the thought of raising an issue where there is a potential for a conflict in values between client and therapist is often overwhelming (Farnsworth & Callahan, 2013). Sexual health in particular may be viewed as a potential site for this kind of value conflict to arise.

It is held to be an untenable notion to believe that it is possible to be value-free and the imperative therefore is to recognise personal values and explore how these are influenced by culture, gender, age, socio-political discourses including the impact of the modern world as an ever present part of the psychotherapeutic process (Alegría, Roter, Valentine, Chen, Li, Lin, Rosen, Lapatin, Normand, Larson, Shrout, 2013). What this highlights is that there is an impossibility of an *ultimate truth* which in turn raises the question of whether objectivity can indeed exist (Markovic, 2013). The importance of this view is that it demands a therapist widen her focus to incorporate paying attention to people *within* systems such as the systems of gender, culture and age (Markovic, 2013). It is currently held by many that postmodern thought "begins to allow a space for ethically rich conversation" (Alegría et al. 2013). Alegría et al (2013) suggest that it is during the process of therapist and client being able to recognise differences in values and moralities, within a trusting, empathic relationship, that change may happen through the discussion of such differences. The subjective experience of the self and of sex, sexuality

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and intimacy becomes overwhelmed by the modern era to reduce things to quantifiable variables and the subjective experience is replaced by a list of criteria or symptoms (Perel, 2007). It has been argued that clinicians should be able to transcend and set aside their own personal values in order to best aid the client's therapy process (Farnsworth & Callahan, 2013). This is what the postmodern paradigm hinges on. However this may be difficult to achieve in practice and the attempt to maintain neutrality may in itself give rise to conflict and cause the therapist to remain unaware of her own personal beliefs and the impact of those beliefs within a therapeutic context. The salient feature of this argument is that it is imperative for a therapist to be aware of her own values and belief systems (Farnsworth & Callahan, 2013). In order to achieve this it required that the emergent identity of the developing therapist, is offered the opportunity to explore and understand the self-development of herself during the training program as put forward by Pascaul-Leone et al. (2013). Post structuralist ideas posit that identity is relational and contextual and therefore cannot be fixed (Russell & Carey, 2004).

2.11. Reflexivity

Reflexivity is a process that encourages and includes the researcher's beliefs, values and thoughts and embraces moments when the researcher remembers to look at herself (Terreblance, Durrheim & Painter, 1999)

I felt that it was important to add a note on the reflexive nature of this research project, hopefully to add further depth into my own rationale and aims for the project. Reflexivity is described by Willig (2008) as being an important aspect of qualitative research as it encourages the researcher to reflect on ways in which the researcher is personally implicated or affected by the research process as well as the affects of the findings. The importance of circular questioning is strongly encouraged in an effort to develop reflexivity and self-healing (Madigan, 1993).

CHAPTER THREE

3. RESEARCH METHODOLOGY

The focus of this research project was that of how trainee psychologists deal with gathering information around sensitive topics such as sexual health. An important aspect of the research is in the attempt to understand themes that arose from the semi-structured interviews and the

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meaning that the trainee psychologists attach to the topic of sexual health. The aim is to explore the experiences of the sexual assessment part of the clinical interview. Qualitative research of this nature is therefore interested in the quality and texture of the experience and not with the identification of the cause (Willig, 2008). The research aims at looking closely at what the experience was like for trainee psychologists, during the initial interview with a new client, specifically at the time of attempting to ask about sexual health. The emerging themes are used as an aid in attempting to make meaning of the experiences in a way that can enlighten one on the texture and quality of the experience and perhaps lead to further investigation around meanings attached to sexual health matters. Qualitative research allows for exploration into the meanings the participants attributed to events specific to this research (Willig, 2008). This research attempts to describe and possibly put forward some points to stimulate discussion pertaining to the events and experiences within a specific context, and not to predict (Willig, 2008).

3.1. Introduction

The requirement of questioning around sensitive topics, such as sexual health, combined with the discomfort that appears to be present in many trainee psychologists creates an interesting space to ask the question: *How does the trainee navigate a way through this complexity?* This research is therefore an exploration into how the trainee deals with this line of questioning seeking an exploration and retrospective look into the experiences and feelings of those moments with the intention to extrapolate thematic understandings of some of the meanings attached to these challenges. Qualitative research design allowed the platform for this research project to be built.

3.2. Aim

The research explores the processes the trainee psychologists employed when gathering a history of a new client, specifically around the sensitive topic of sexual health. The topic of sexual health represents a sub-context of training with regard to the clinical interview which is taught in the Psychological Practice module as part of the Professional Program at a Masters Level for Clinical and Counselling students at the University of Kwazulu Natal. This study is interested in whether trainee psychologists are adequately prepared or have adequate knowledge of the topic of sexual health in order to question a new client in a sensitive manner with the aim of gathering

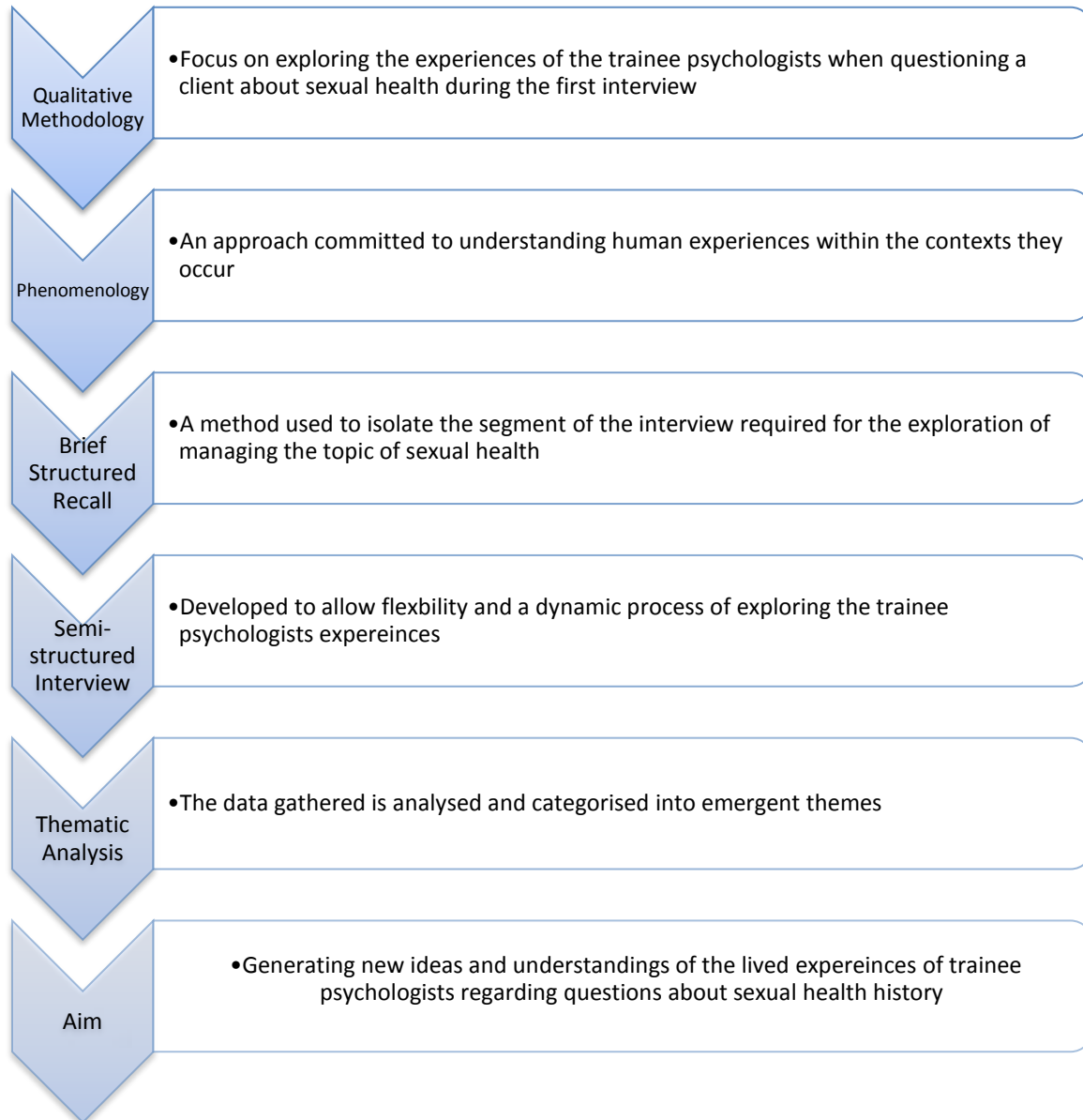
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a complete history. The research explores the impact of these questions on the working alliance and the skill required in addressing any discomfort in the trainee or client during the process. The objective is to understand what factors may cause interpersonal discomfort or escalate performance anxiety, and factors that the trainee may draw on to overcome these challenges.

3.3. Research Questions

- Obstacles faced by trainee psychologist when addressing sensitive topics: sexual history
- How the obstacles may affect the therapeutic alliance
- Overcoming the obstacles

Diagram 1: Methodology



3.4. Methodology

3.4.1. Research Design

3.4.1.1. A Qualitative Study

The research design is a qualitative study. This design is used to capture the complexity of human interactions and experiences (Ward, 2008). The research is exploratory in nature and was therefore designed to accommodate an open and flexible investigation. An exploratory design allows for the researcher to make a series of observations around specific phenomena in this study, specifically around the topic of sexual health during the initial interview. These observations become part of an attempt to group these phenomena together in a way that generates a general but speculative suggestion as well as to generate further interest in the area (Terreblance et al.1999). According to Terreblance et al.(1999) a salient feature of a phenomenological design is what is described as "the self-world relationship" which in this study focuses on the trainee self and how that self engages with and makes sense of the world specifically in terms of understanding and dealing with the topic of sexual health. In order to fully understand why and how a person responds, reacts and lives in the world it is vital to understand the context from which she comes. It is near impossible to separate the self and the world, or subject and object requiring a deep understanding of the person within the relationships of her life and experiences of her world, a deeper structural understanding of the self (Terreblance et al. 1999).

3.4.1.2 . Phenomenological Framework

The phenomenological approach is committed to understanding human experiences and phenomena within the context they occur. The leading feature of this approach is that it is rooted in an existential - phenomenological approach which means that it is a paradigm concerned with the very core of human existence rather than the a metaphysical reality (Terreblance et al. 1999). This framework falls under the *interpretive* umbrella in that it focuses on the subjective understandings and experiences of people (Terreblance et al. 1999). The fundamental nature of research based within this paradigm is to gather information in such a manner that allows one to become familiar with and get to know the phenomena in its real context as it emerges (Terreblance et al. 1999).

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This framework is appropriate for this study as it is the subjective experiences of the trainee psychologists that are the focus of the study. It was anticipated that, through combining the Brief Structured Recall method and the Semi-structured Interview, would allow the subjective experiences of each trainee to be presented in rich detail. This detail allowed themes to emerge as the phenomena arose. The phenomenological framework aims at allowing voices to be heard.

3.4.1.3. Brief Structured Recall

The method of Brief Structured Recall (BSR), which was be used for the purpose of this research falls under a larger paradigm of Participant Critical Events (PCE's). A PCE is a method utilised for the purpose of isolating and reviewing certain segment/s in the interview process with the aim of discovering more detail about that segment (Fitzpatrick, 2007). This method is particularly suited to this study as it is the segment of the interview concerning *sexual health* that is required for the purpose of this study. The BSR method allows for the researcher and participant to recall and review the pertinent segment together in an attempt to understand the phenomena (Fitzpatrick, 2007). This is done by means of isolating the required segment of the initial interview and using the semi-structured interview as a means to explore details of the participants experience. The BSR is well suited due to the fact that it requires a relatively short interview period with the participant (Fitzpatrick, 2007). This is important as time constraints for post-graduate students may hamper participation and a shorter interview results in less chance of participant fatigue (Hill, 2004). It is estimated that the interview will take between 20 and 40 minutes (Fitzpatrick, 2007). The interview process will be recorded and will then be transcribed verbatim.

3.4.1.4. Validity and generalisability of qualitative data

Measurement validity is defined by the extent to which a measure actually does what it was intended to do (Terreblance et al. 1999). It is important that there is a good match between the "conceptual and operational definitions" of the particular construct and that it is well suited to gather the data that is required for the research project (Terreblance et al. 1999). Unlike quantitative research which uses standardized questionnaires, qualitative research uses methods such as interviews (Willig, 2008). However the implication of using *interviews* as a data collection method is that the validity of such measures, which are based on subjective inputs

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from participants, may be questioned (Willig, 2008). However many researchers argue that qualitative research is valid in its own right and that there are many ways in which questionable validity may be examined further (Willig, 2008). According to Willig (2008), ways in which validity may be checked are:

1. Qualitative research being accessible to other researchers for further scrutiny
2. Throughout the research process to allow input from the research participants to check the meaning once data has been categorised and interpreted
3. For the phenomena to be studied in its real context which increases the “ecological validity”

An important part of any research is the question of generalisability, also known as external validity, which looks at the degree to which it is possible to take the specific data and outcomes from a research project and transfer the project and its findings to a wider population group and to various settings (Terreblance et al. 1999). Although data from qualitative research can be context specific, future research can confirm perspectives or disconfirm perspectives making it more generalisable for use and appropriateness in other contexts (Willig, 2008). Generalisability is important as it is the crux for researchers to be able to make "universal, theoretical claims" as well as to be able to describe population groups, building on existing research, expanding and extending it and allowing other researchers to review and further develop the research (Terreblance, et al. 1999). It is anticipated that this research project will stimulate further research in this area and generate broader discussions regarding the topic of sexual health.

3.5. Sample description and motivation

For the purpose of this study, the method of non-probability sampling was used. This form of sampling is used when the selection of participants is not yielded through the principle of statistical randomness. (Terreblance, et al. 1999). The purpose of using such a sample is that often it is required that researchers utilise a group of people who volunteer to participate and this is known as a convenience sample (Terreblance et al. 1999). Specifically for the purpose of this study *purposive* sampling was necessary as it relies on the availability of the trainee psychologists in the Professional Training for Professional Psychology program at UKZN as well as their willingness to participate. It is important that the cases selected are representative

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of the population selected as well as being adequate for research purposes (Terreblance et al. 1999).

Twelve participants were selected on the basis of the following criteria:

- 1.) currently must be trainee psychologists in either counselling or clinical field;
- 2.) must be a trainee at a postgraduate level ;
- 3.) must be actively involved in the psychological therapeutic process

Participants were selected regardless of gender, age, race, theoretical orientation, marital status and whether the participant is engaging in the psychological therapeutic process for the first time or not. However the sample will be homogenous in terms of age only. Participants will be required to be part of the study with a focus on their adult clients aged 18 years and over.

3.6. Instrument Development

The semi-structured interview schedule was developed using a scientific approach whereby as much of the relevant literature was read as possible as well as consulting with experts in the field of sexual health. Core themes were isolated and these key areas of interest guided the process of focusing the questions of the semi-structured interview in order to gather pertinent information for the research project. Brief Structured Recall (BSR) requires a 20 to 40 minute interview duration which seemed to be a good fit considering the busy schedules of trainee psychologists. The BSR requires that both the researcher and participant become "co-investigators" in the exploratory process (Larsen, Flesaker, Stege, 2008). Due to this it is important that the semi-structured interview allowed for open and flexible conversation during the interview process and for the implicit to be made explicit. This can be achieved through having a conversation about what is being recalled and experienced by the participant (Larsen et al. 2008). Specific questions were used in order to probe some of the experientially driven meanings that participants generated from interviewing clients about this aspect of investigation. This included the experiences as well as the observations made by the participants during the interview process (Larsen et al. 2008). Therefore the intention of the semi-structured interview was to allow for

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the participant to explore and be curious about their recalled experience of the segment of the interview and for conversation to arise through the experience while sitting with the interviewer.

3.7. Data collection

The Brief Structure Recall method required the participant to recall specific moments during the initial interview with a new client. The participant had an opportunity to reflect back on how she experienced the initial interview (specifically regarding the topic of sexual health) at the time and to share her feelings and personal insight, self-talk and other thoughts and emotions that came to the fore during the interview process with the researcher. The semi-structured interview was used as a guide to gather information from the participant.

The interview served to explore the obstacles the trainee psychologist experienced during the initial interview while gathering information around a sensitive topic such as sexual health. The process for data collection commenced with the interview where the researcher and participant discussed the relevant section of the initial interview needed for the research purpose using BSR. The benefit of using the interviewing process is that it offers the researcher the scope to get to know the participant and develop some insight into the thoughts and feelings of the participant (Terre Blanche & Kelly, 2006). Semi-structured interviews not only allow for flexibility informed by on the uniqueness of each interview situation, however, also was designed in such a way that allowed the participant to respond in her own words which further prompted the participant to broaden her own meanings and interpretations to emerge (Davies, 1999). The form of the semi-structured interview provided some guiding questions and scope for the natural flow of conversation and furthermore offered the participant room to explore her thoughts and feelings. The interview presented the opportunity to allow the personal experiences of the trainees to arise as openly and naturally as possible which is in line with the aims of this study which is to allow the phenomena to come to the fore.

3.8. Procedure

Permission was sought from the Centre For Applied Psychology at the University of Kwazulu Natal. Participants were contacted and selected on the basis of their willingness to participate and discuss the topic openly and honestly in the form of purposive sampling. Participants were informed of the objectives of the study as well as the applicable ethical considerations

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throughout the research process. The participants were not requested to write their names or any information about who they are on the informed consent to ensure anonymity. Participants were made aware that they were free to discontinue at any stage without prejudice from the researcher.

Informed consent forms were given to the participants which briefly explained who the researcher is, the purpose and importance of the study. Information given included the amount of time it would take the participant to complete the semi - structured interview as well as time required to participate in the interview and confidentiality issues. Contact numbers of both the researcher and supervisor were included in the consent forms in the event the participants required further information about the study. Given that the participants are part of the Professional Program at UKZN it is a procedure the trainees will be familiar with.

The interviews required a maximum of 60 minutes. This time allowed for introductions, consent forms, orientation and information about the study as well as time to answer the semi-structured interview. Each interview was recorded with the consent of the participant and subsequently transcribed verbatim. Recordings were checked randomly to ensure the sections of the recording were adequately compared and matched to their transcripts as a quality control measure.

3.9. Data Analysis

Operating from an interpretive paradigm this research employed a basic thematic analysis, which is in line with the research conducted (Rubin & Rubin, 1995). This study seeks to access people's subjective experiences therefore the aforesaid method of analysis is most appropriate. This design used the BSR framework, and a semi-structured interview to gather information from participants. Each participant was asked to recall the section of their interview relevant to the research question: gathering information about sexual health. The data gathered from the study was studied using thematic analysis, in order to classify common themes that arose. During the process of preparing for analysis it was assumed that a preliminary understanding of the data would emerge (Terreblance et al. 1999) . The transcripts were studied in great detail and notes were made during the process. The data was categorised according to the common themes as they emerged with a focus on issues such as gender, culture, generational aspects and personal struggles for the trainee psychologist.

Data analysis was based on thematic analysis using the following steps:

a. Familiarisation and immersion:

Once data has been collected it requires involvement with the data and the development of ideas (Terreblance et al. 1999). It is necessary to read the transcripts of the interviews a number of times in order to know where to find information and how the data may support interpretation (Terreblance et al. 1999).

b. Inducing themes:

Through looking at the data there will be themes and ideas which become apparent and this is known as a "bottom-up approach" (Terreblance et al. 1999). This step requires more than simply summarising the themes and requires rather a greater understanding of processes, tensions, contradictions and functions underlying the data (Terreblance et al 1999).

c. Coding

The process of differentiating between themes and sorting information into categories is what is termed to be coding (Terreblance et al. 1999). During this process different sections of the data is marked in order to sift through information that is relevant to the research and that which is not (Terreblance et al. 1999).

d. Elaboration

During the stage it is required that themes are explored deeply in order for the researcher to gain new understanding of the data or find deeper meanings that emerge from the data to develop themes (Terreblance et al. 1999).

e. Interpretation and checking

At this stage the researcher is required to reflect on all themes and sub-themes that have emerged and providing an understanding and context of the data (Terreblance et al. 1999).

3.10. Ethical Considerations

Ethical clearance for the study was sought from the Postgraduate Research Ethics Committee (Applied Human Sciences) at the University of Kwazulu-Natal.

Informed consent was obtained from each participant. Each participant was made aware of their right to withdraw from the study at any stage. Permission was gained from each participant to record the interview.

3.11. Cost Estimates

The total cost of the study should be R1000.00. The costs include printing of the data once transcribed and printing of the final research project. Recording equipment is available free of charge.

3.12. Limitations

In order for the results of this study to be generalisable it is recommended that further research is carried out in other training centres. This study would need to be replicated in various setting with participants from different training centres with a homogenous sample of trainees and clients that are similar to the current study to establish generalisability. The current study is situated within the contextually determined socio-demographic environment within an urbanised setting. It would be recommended that the study be replicated and extended amongst different age cohorts in relation to clients and other demographics.

It was anticipated, due to the literature review, that the working alliance would be affected by questioning around sensitive topics such as sexual health. However it was not found to be a significant factor within this study and other variables such as gender, culture and age seemed to have a more importance for the participants.

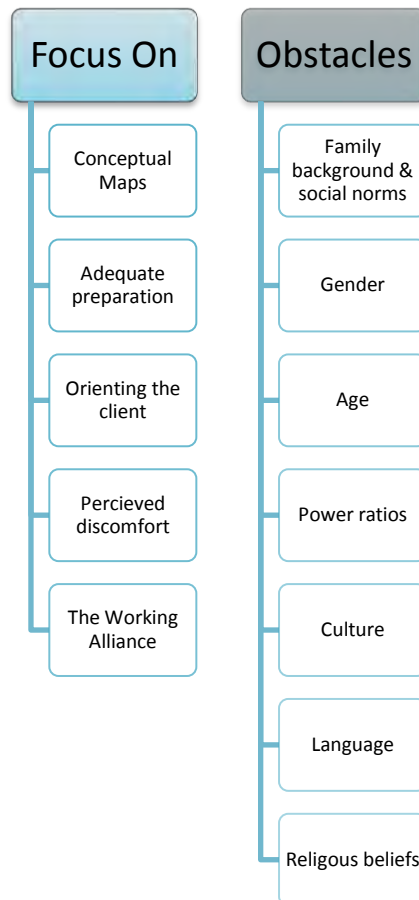
CHAPTER FOUR

Reflexivity is an important part of the research project and where appropriate I have added my own personal experiences or insight. The importance of this is to include how my presence, thoughts and context affect the research process.

4. FINDINGS

The aim of this research is to understand the obstacles faced by trainee psychologists when conducting a first interview with a new client, with the aim of gathering as much history from the client as possible, including sexual health information. The emergent themes were derived from the individual interviews which were transcribed. Through the conceptual framework guiding the research project and a thorough analysis of the data the following emergent themes were highlighted in gaining deeper insight into the challenges trainee psychologists experience when broaching the topic of sexual health during the first interview.

Diagram 2: Emergent Themes



4.1. Conceptual maps

4.1.1. The first clinical interview

There seemed to be general consensus among the participants that the initial interview is an anxiety provoking experience related to the task of gathering information. The participants found that the structure of the Morrison Interview (Morrison, 2007) was a useful tool to contain their anxiety related to the specific process of conducting the first interview. Conversely it was also a tool that increased task specific anxiety due to the expectation of being required to following it thoroughly.

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Participant 3 (female): I felt it [the intake interview] was very overwhelming. I felt that I needed to get structured information down and I wasn't getting into it because she [the client] had so many issues and she just kept on going and I wanted to draw her back. So to contain [her] was really difficult.

Participant 4 (female): I think most of the first interview one feels quite anxious about things because it's the first time you're meeting someone and you aren't sure of what to expect. So naturally that experience for me personally was a very rigid one because I had prepared, probably way too much for it. So I was necessarily relaxed with my planning for it, but once it started, because I had a plan and structure that I followed I then eased into it, I could forget about it and let things flow.

Participant 1 (female): For me being the first time I felt a bit anxious, I felt a bit all over the place even though I had structure.

At times the structure was described to have inhibited the flow of the initial interview and resulted in the experience of the process being mechanical.

Participant 6 (female): ... you seem to get stuck on just ticking boxes than rather engaging in a conversation. So it limits the flow a lot and you miss a lot and I notice from watching my first interview when I would ask a question, I would be told something quite important by the client but I didn't pick up on it because I was preoccupied with what the questions should be next and I missed the opportunity to go into what was important.

For one participant the structure was a tool that managed to contain some of the above mentioned anxiety and offer guidance.

Participant 7 (female): The structure did assist. You know reading about it helps you so much but eventually it becomes a practical experience in that the more interviews you carry out the better you are at understanding the gathering of information.

Although the structure served to offer guidance for a trainee psychologist in managing the amount of information required, the lack of experience and understanding regarding gathering sexual health information posed challenges for some participants.

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Participant 4 (female): I don't think we know enough as to why we ask, when we do...How useful is it [sexual health information], and if we don't think why we are asking it we are not going to use it properly.

Participant 5 (male): Yes, I felt I had to ask these questions, on some aspects I didn't really know how these questions would help but never the less I had to ask them...Some sections had relevance, some sections didn't have much bearing on what we were discussing.

The comments below illustrate how the limited conceptual maps concerning sexual health limits the ability to manage the topic adequately.

Participant 7 (female): I think because it's not a topic you discuss with just anyone and being a new clinician I didn't have the confidence in order to ask that question without showing my anxiety.

Participant 8 (female): I think just asking about their sexual experiences, their sexual libido, personally I didn't know what to say about that, because I personally was not sexually active while doing this so I felt very inexperienced, I didn't even understand how was their first time, how frequently, I was young, I didn't know.

Participant 5 (male): In my intake I don't go back to that, asking about sexual experiences, I don't know what I'm going to do with that, what information do I need and what am I going to do with that, why am I asking you that?

As the comments illustrate, the trainee psychologist has a plethora of thoughts and processes to manage during the task of gathering information during the initial interview. One participant felt that her work experience had assisted her with managing the topic as she had developed conceptual maps regarding this topic.

Participant 3 (female): I think it was really easy for me to ask because I have worked in the sexual assault unit so it's no longer a sensitive topic for me so it's something I just would have asked, in saying that when I did ask the question I did notice that the client was taken aback, which did make me think that this was probably sensitive.

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4.1.2. Adequate preparation

Process Issues

During the course of training to become a psychologist there are many areas that are included in the theoretical component of the program such as child abuse, alcoholism, HIV/AIDS, Suicidality, psychopathology to name a few. The practical component teaches the trainee psychologist skills of how to conduct the first interview with a new client using the Morrison Interview Schedule as a guiding tool (Morrison, 2007). Some participants in this research project felt that there had been adequate preparation regarding how to conduct the first interview in terms of gathering a general history from the client. According to Fontaine & Hommond (1994) the focus of training programs usually rests on building a repertoire of skills to employ during the counselling process.

Participant 4 (female): ...initially you had that long list [the interview schedule] of absolutely everything that you need to find out about this person in fifty minutes and it would almost be impossible to do, if you would go through that check list verbatim as if you're almost in hospital you probably won't get through it in an hour or fifty minutes but when you have a conversation about it, it makes it possible.

However, what seemed evident is that this can create a disconnect between the act of performing the process of the interview and gaining deeper insight in understanding the more complex issues of the counselling process (Fontaine & Hammond, 1994).

Participant 5(male) : So it created that barrier between me and the client because I felt that I had to get as much information as possible. You keep checking that do I have this, should I ask that so it really puts you on edge for a first interview.

Another participant felt she was not prepared for the process of the interview due to having to manage a variety of different areas of inquiry. The content inhibited the process somewhat.

Participant 7 (female): The very first one [client] I saw I would say no, simply because in my mind it was more getting the right information, also conducting an adequate mental state examination, so at that stage it was trying to negotiate: you're asking the person the questions,

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you're trying to get the information, trying to assess the client, so yes that was the problem with that.

One participant felt overwhelmed by her own 'self-talk' and struggled to focus on the content due to intent focus on the process of the interview.

Participant 8 (female): ... there was a lot of structure to it [the interview process] so we [peers] spoke about a lot of self talk in the process of interviewing and sometimes that got in the way because you'd say: 'I forgot to say this and I forgot to say that'.

Another participant felt that her past experience of working in a sexual assault unit had normalised the topic and vocabulary of sexual health resulting in her finding it easier to follow the process of the interview in its entirety. However, this participant felt that due to the diversity of the population it was doubtful if one could ever be completely prepared.

Participant 3 (female): I don't think you are ever adequately prepared or feel confident enough so at the back of your mind you're always thinking: I have to remember to ask certain questions, so you lose focus a bit.

The practical component of the Professional Program for Training requires that trainees have opportunities to practice their newly learnt skills of interviewing clients and becoming familiar with the process of the interview. One of the opportunities to practice these skills is during role-plays where groups of students are able to use the interview schedule and simulate an interview in a therapy room. During role-plays despite having the Morrison Interview schedule and being instructed to role-play the interview process it emerged that the full interview was not completed by many of the participants as most had avoided the topic of sexual health.

Participant 1 (female): ... we did do practice rounds but... we did speak about it [in class] but everyone was wanting to avoid it, so we just said: let's make it easy, we won't make it awkward or anything like that... We re-watched it [recorded segments of the role-plays] in class, we didn't focus on that either, so I wasn't really sure, we did mention it in class.

Participant 3 (female): ...we did alcohol and drugs[questions during the role play] but not sexual history and sexual functioning, strange why we did not do that.

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Participant 5 (male): [when asked whether the group had practiced talking about sexual health] No. No never.

Participant 7 (female): No I avoided it even in role-play, even with the people who were in class with me, I know I avoided it.

One participant described how during role-plays the group focused more on the process and mechanics of the topic of sexual health than on how to manage the actual content of sexual health.

Participant 6 (female): ...we practiced asking about it but I don't think we really did it properly, because in our group we just focused on the wording aspect but not dealing with anything else, but purely of how we would say it, in terms of words we would use.

Content Issues

Although the participants felt prepared to some extent to conduct a first interview and understood the process there appeared to be ambivalent sentiments regarding preparedness for addressing sexual health content. Although learning through experience is invaluable, for the trainee psychologist this experiential data base may be limited, particularly regarding the topic of sexual health. Therefore it is important to develop as much theoretical data as possible in order to assist the trainee to adequately deal with incidents which may be confusing during the first therapy sessions (Fontaine & Hammond, 1994).

Participant 5 (Male): I think we were prepared [for the initial interview]. When it comes to the sexual history that is the main portion that I felt wasn't really targeted, I wasn't really happy with that, for example from my side the gender, the culture, the age. So looking at that I feel I wasn't adequately prepared.

It appears that learning and following the process of the first interview is less challenging than attempting to manage the content of the interview.

Participant 8 (female): I didn't see the need for it [to ask about sexual health], I just did it because I had to do it.

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Participant 2 (male): Yes with all training and practicing I'm comfortable with but when it gets to issues around sexual history and suicide and that kind of sensitive stuff I'm not comfortable with.

One participant had role-played gathering a sexual history from a client and had managed the process of the interview adequately. However, it was due to the role-play experience that this participant was alerted to her own discomfort around the content of sexual health.

Participant 8 (female): I was stuck, at that point of the interview [during the role play]. I felt stuck I didn't know how to word it correctly, I fumbled, mumbled, lost my eye contact, looked down, so I felt it wasn't really addressed sufficiently, that specific area [questions about sexual health]. I didn't realise how difficult it was to talk about until [I] was put on the spot.

Linking process and content

What has emerged is that despite the first interview being a challenging experience for many of the participants, the structure of the interview appears to assist the process. It lends itself to containing some of the task related anxiety and offers guidance to ensure a maximum amount of information is gathered from a new client. It seems that the difficulty arises when attempting to gather history around sensitive topics such as sexual health and that most of the participants struggled with how to manage the content.

Participant 7 (female): ...in M1 [Master training in Psychology] give me the interview sheet and go through that whole thing with me, tell me why are we asking about sexual history. If the client says this, what is the possibility of that meaning, yes so I think that would be helpful [to have understood why sexual health is required content].

The quote below illustrates the disconnect between process and content, that questions about sexual health are asked purely by default as being part of the process of the interview.

Participant 9 (female) : We asked it but we never did it in depth, it just didn't seem relevant.

Personal Reflections: It was during this part of my training that I first became aware of the discomfort some trainee psychologists experience when talking about sexual matters. During our group role-play one of my peers struggled with finding any words that she was comfortable

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with and wanted to avoid this line of questioning altogether. After the role-play she was visibly upset with the fact that she felt so limited in her understanding of sexual matters and her limited vocabulary regarding sex and sexual health. We seemed to be adequately prepared in understanding the interview process yet the segment of sexual health remained an area where most students did not know how to manage the content and feeling overwhelmed by the complexities of sexual health.

4.1.3. Orienting the client and interest in sexual health information

At times a client has come to therapy for the first time and may be uncertain of the mechanics of the process. Thus it is important to orientate the client and contextualise the process as well as to discuss the expectations of both therapist and client (McWilliams, 2004). During the orienting phase, confidentiality is discussed and the need to gather information from the client is explained in order for the clinician to get to know the client better. The orienting process appears to be aimed more at familiarising the client to the process than orienting the client regarding specific content.

Participant 5 (male): Well one of the things I did correctly was orientation, I did orientate my client saying this is what we are going to do today. In a way I felt it put me at ease as well as the client so he knew exactly what we were going to do.... To be honest it was just a general orientation not specific issues...

Although many participants oriented their client to the therapy process the topic of sexual health was avoided during the intake interview. Most participants felt they did not want to alert the client to possible sensitive topics. From the comment below there appears to be a clear indication of how the process of the interview was adjusted to accommodate the 'readiness' of the client to talk about sexual history.

Participant 7 (female): No not around sensitive topics, in the orientation process we are going to collect, it was just made mention to the client, information will be gathered: family, school, education, career etc, but no specific mention that it might be sensitive information.

What appears to be evident is that during the process of the interview the participants were able to adjust the questioning process and be guided by a semi-structured interviewing format.

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Adjusting the interview highlights the importance of dynamic questioning rather than straight forward questions and answers. Linear questioning can at times shut down the conversational tone of therapy (Markovic, 2013). The importance of dynamic questioning and assessing each client and therapy as unique is highlighted by a participant who raises these issues as well as questioning the client's response.

Participant 7 (female): I think it's relevant always and I think rapport is really important in questioning. However, when it comes to certain presentations in front of you, you have a certain obligation as to whether this person is able to provide you with truthful and responsible account of what it is that you want to know and not just something that is going to end it... the topic.

Examples of further orienting the client to the possibility of difficult questions:

Participant 1 (female): Yes I do say that some things might be a bit sensitive and they [the client] might be a bit uncomfortable at times but they must be honest and open, and not talk about things that are too uncomfortable at that moment.

Participant 2 (male): Yes I do follow the form and tell them it's going to be a process of asking questions and to be as honest as we can be.

Participant 3 (female): I just said that some of the questions might seem irrelevant or might seem strange, I didn't use the word 'sensitive' at all...

One participant indicated how the idea of dynamic questioning was already a concept she felt would assist her when dealing with any difficulties that may arise during the interview.

Participant 4 (female): I didn't have a specific plan for sensitive topics but I think that for me you can't really prepare for this, probably better if you don't prepare for it because you're going to handle it in a more real kind of way, I guess my plan just to take it and work with each person.

Yet another participant had no expectation about how to manage sensitive topics such as sexual health.

Participant 5 (male): I didn't have much expectation....I didn't know how to ask it [sexual health questions].

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Observations made by some of the participants were that they did not understand the relevance of asking about sexual health or gathering a sexual history during the intake interview. There seemed to be a disconnect between how this information may be useful and how the information may be used by the trainee to expand her understanding of the client. It seems that the structure and using the information schedule is a way not only to contain anxiety but also serves the purpose of being a justification to enquire about sexual health. Questions about sexual health are at times framed as a medical requirement to rationalise why such sensitive or intimate questions may be asked. This seems to be in relation to where the field of psychological practice is currently positioned (Markovic, 2013). The assumption that sexual health falls within a biomedical model and allied health is perpetuated by the belief system that wellness is the absence of illness. Thus the absence of sexual health problems implies wellness in that area. In the field of psychology expression of sexuality, sexual preference and issues around sexual functioning have had the unfortunate position, historically, of being considered to be pathological when not conforming to moral standards of society (Foucault, 1980). It would appear that asking about sexual health is deemed more appropriate if it is directly related to the referral question.

Participant 10 (male): It would depend on the problem she came in for, I would try and probe and ask questions around it, indirectly it's not something I feel comfortable with asking directly, sexual history is something I feel very uncomfortable speaking about it.

Contrary to this view one participant expressed her understanding that by positioning the topic of sexual health alongside and with equal emphasis as all other areas of inquiry may actually ease the discomfort felt by herself and her client.

Participant 3 (female): I ask it in such a way that it may come across as just part of the questionnaire which I have done before, so if I'm awkward about it that would have an adverse reaction. For example the client even though she was of a similar age to me, she felt good, because the questionnaire followed structure it became less awkward. I was thinking that she felt: let's just continue answering the questions. So I think that makes a difference because it's in a structure. If I had to zone in on it, it would make it more sensitive, I presume, I'm just guessing now.

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It is worth considering that it would be time consuming to have to explain to every client the role of sexual history and broadening the view of the client, and to rationalise any enquiries concerning the subject, in relation to the client's reason for coming to see a psychologist. However, if the trainee psychologist understands the relevance of this area of enquiry, then this inevitably informs her judgment as to how to proceed with it using dynamic questioning.

Participant 5 (male): When you are going to speak about those sensitive issues it's going to be uncomfortable so I'm not going to talk about this until we get there, I don't want to anticipate that bridge until we get there, it's [the segment of sexual health] not the entire session.

Participant 6 (female): ... I didn't want to alert them [the client] to the fact that it was sensitive because it makes it more difficult for me to ask. So no I didn't [orientate about sensitive topics]

Orienting the client seems to be linked with being able to build rapport with a client and is succinctly summarised as follows:

Participant 7 (female): I think orienting them is very very important, each person's structure is entirely different, through orientation rapport is being built, so although we may end up talking about something sensitive today it is important that they come back and with consistency rapport is being built and assists with sensitive topics.

Personal Reflections: During this part of the interview with some of the participants, I shared some of my understandings of why this information could be useful. As indicated in the literature review there are many factors such as relationships with others, body image and self-esteem issues that may point to this line of questioning as being relevant and useful. This has been an area of personal interest due to the fact that sexuality is often only understood within a medical framework hinging on symptoms and diagnoses. My interest is in seeing the person as a whole, within their context and including all facets of their lived experience.

4.1.4. Perceived discomfort

4.1.4.1. The process of the interview

Generally the participants were prepared for the process of the first interview. Despite some anxiety related to the task of conducting the first interview, the structure of the interview

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schedule alleviated this to some extent. A pertinent debate seemed to be around the issue of the timing pertaining to when to enquire about sexual health and whether it was appropriate during the first interview or should be raised in subsequent therapy sessions.

Participant 8 (female): One's not too sure, do you start with it? Or right at the end of the interview? It is quite tricky but I think as you get to know the client you get to almost being able to judge when to talk about a sensitive topic, like tests or trials, see how they respond to that and then ask about it, but you don't get taught that either.

Participant 9 (female): It was ok, the structure of the forms I don't like especially with the sexual history it pops up in between the group questions and it is awkward.

Furthermore this participant explained:

Participant 9 (female): Yes I do actually because I think especially for therapy unless it's an assessment on sexual functioning. But I think for therapy you could bring it up in your third session but we are asked to do it in the first session. You don't even know the person, they don't even know you, it's fifteen or twenty minutes into the session and you ask them are you having sex with your wife or how long is it that you have not been having sex.

One participant perceived that enquiring about sexual health hindered the process of the interview.

Participant 5 (male): ...it [asking about sexual health] didn't assist in the process at all because there was discomfort on both sides, from my side and the clients' side as well, and again it felt like there was not much relevance. So I wouldn't say it hindered but it didn't really assist in the process as a whole.

There were a few participants who were able to broach the topic of sexual health and prior to this line of questioning did not seem to have as much anxiety linked to the task as the others did. The discomfort appears to have been felt acutely within the trainee and not caused by anything said or done by the client. Following the process of the interview alleviated managing issues with the content, however, as the following comment highlights there are many other factors that may impact the decision to raise certain subjects.

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Participant 7 (female): It may not be an invasion of privacy but in the process of gathering information that question could be asked at a later stage, if you have someone so severely depressed it could be difficult to ask them that question [about sexual health].

Although the process of the interview seems to be clear for most participants there are instances which confuse the process. An example is when one participant describes her discomfort at conducting a parent intake and being unsure whether the topic of sexual health was relevant to discuss in terms of the relationship between the parents.

Participant 9 (female): Yes and you have to ask them also about their sexual history and how intimate they are and I find that a bit irrelevant, it could be, there may be some issues there but I still think it's irrelevant.

4.1.4.2. Content and initiating this area of inquiry

During the moments prior to asking about sexual health most of the participants experienced feelings of anxiety that seemed to be linked to the content of the questions. The anticipatory affect related to the task of initiating inquiry into sexual health and appears to have had an impact on whether the trainee was able to ask the questions about sexual health or not. Those who felt they had limited experience in engaging in the topic of sexual health tended to avoid the topic altogether.

Participant 8 (female): I think just asking about their sexual experiences, their sexual libido, personally I didn't know what to say about that, because I personally was not sexually active while doing this so I felt very inexperienced, I didn't even understand how was their first time, how frequently.....

Once the topic of sexual health had been raised some of the participants clearly perceived discomfort in their clients due to the content of enquiry.

Participant 3 (female): I think it [the topic of sexual health] was unexpected, then saying that she was taken aback but then she was happy to answer but it did take a moment...not discomfort, just the initial surprise.

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Participant 8 (female): ... she would look down, smile, be quite, I would then comment on her being quite, we may then carry on with that or I would just leave it all together because I'm pushing too much so let me come back to that...

A participant noticed the client's discomfort through facial expressions and a delay in responding to the questions that had been asked.

Participant 5 (male): ... facial expression and response time, they don't respond as with other questions, they pause, and it's like, why are you asking me that question?

There is awareness in the trainee psychologists that much of the discomfort arose within themselves and their own discomfort may actually create the discomfort experienced by the client.

Participant 8 (female): I felt that when I stumbled or hesitated that caused the client to react, either laugh or look away.

One participant felt acutely aware of the fact that the content of sexual health was difficult to deal with due to the newly formed working alliance between himself and his client .

Participant 2 (male): I know so little about the person on the other side and I am asking incredibly personal questions, which I don't know how to phrase it right and I don't want to cause disrespect...

Discomfort in the client fuelled the feelings of discomfort experienced by one of the participants.

Participant 9 (female): Yes he paused as well I could see he felt a bit awkward, he smiled and I think he also wanted me to go over quickly, he didn't say much either just it was fine it was good so I could tell he felt awkward so that made it more awkward for me.

One participant explains how she does not feel comfortable to raise the topic of sexual health unless there is a clear indication to do so, linked to the referral question.

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Participant 1 (female): ...if it is a presenting problem I don't have an issue with it, they have brought it forward so I'm going with it, compared to the sexual thing, if I brought it up then I'm uncomfortable.

The complexities related to the topic of sexual health make it difficult to comprehend why it is so challenging and why it ignites such discomfort for the trainee psychologist.

Participant 9 (female): Maybe it's the difficultness of sex, it's the physical rather than other things we're talking about,, stuff that perhaps happened in their childhood, it can be intimate if it happened as a child so long ago but even in the present it's so physical and it's something that we all experience. A client can talk to me about being abused or molested as a child and I have never experienced it but I can sit and listen to it but when it comes to sex or sexual history I'm sure we've all engaged in some form of sexual activity so I think that it's more of a reality for you sitting talking to somebody about their sexual history so I think that's the awkwardness.

4.2. The Working Alliance

A key area of interest during training to become a psychologist is that of developing the working alliance between clinician and client. This is highly important to build good rapport where the client may experience an environment that is safe and free of judgment where she can explore and work on challenges that have brought her into therapy (McWilliams, 2004). A psychologist is constantly aware of the therapeutic relationship between clinician and client and needs to be flexible in understating the relationship and how it may be affected by certain topics or interventions.

The process of psychology encourages voluntary disclosure, however, in some cases the reason for referral may not be related to the reason for distress, the client discloses either current or retrospective. The process whilst being dynamic and flexible in relation to the clinical interview is in some ways obliging the clinician to make enquiries which she objectively may think has an impact on an individual's psychological wellbeing. For example in cases where young learners come in for scholastic or academic problems and over time the clinician begins to identify sexual molestation or abuse as a potential perpetrator of problems with concentration and anhedonia. This balance of requiring as much personal information as possible and raising sensitive topics

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which may cause discomfort often leave the trainee psychologist concerned about the impact that such enquiries may have on the working alliance and whether to pursue this line of enquiry.

Participant 4 (female): ... I also think it depends on the person and the reason why they're coming and I think this will determine whether the first interview is the right place to do it or not and I think as a therapist you make a judgment call that this is not the right time. Then the second interview will be the better option it's also something you don't necessarily want to rush into because you want that person to give you honest information you don't want just a generic response.

Semi-structured interviewing seems pivotal in managing the content in a dynamic way rather than using straight forward questions and answers. Dynamic interviewing requires the trainee psychologist to determine whether certain questions will risk the working alliance or if the working alliance is able to cope with sensitive topics being discussed. According to Markovic (2013) it is useful to be able to make suggestions while at the same time allowing space for the client to freely express her opinions and ideas. One participant was very conscious of what the client would think of him if he raised the topic of sexual health.

Participant 2 (male): ... whether they can trust me to be judgment free and also about my reaction

Another participant was too overwhelmed with his own perception of how the client would view him.

Participant 10 (male): ...even in therapy I sit there and think they will perceive me as being forward.

4.2.2. The perception of the working alliance

The trainee psychologist seems to feel the need to ascertain how good the working alliance is at the time of enquiries regarding sensitive questions and whether this may risk that alliance.

Participant 6 (female): ... yes I think that's very important to get that information, however, I don't think it's useful in the intake, as I said neither party knows each other, they are less likely to be honest particularly if they pick up that I'm anxious about asking about it.

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There appeared to be a difference in understanding the type of information that one is looking for and this would be informed by the working alliance regarding the timing of questions around sexual health.

Participant 4 (female): Well what are you really asking, are you sexually active? Yes or no. I think that those ones [questions] you can kind of get your answer and then you can get your history as part of your first intake, but if you're asking deeper more real experiential questions you need rapport.

One participant felt that it was important to have established a solid working alliance in order to ask personal information about sexual health.

Participant 9 (female): I honestly don't know why, I'm very open, I can talk about anything, I just think it's talking to a random person about their sexual history so yes it can get a bit awkward.

Echoing similar sentiments another participant felt there needed to be a good working alliance and rapport before asking questions around a sensitive topic such as sexual health.

Participant 5 (male): ...there has to be a good rapport because it affects their [the client's] ability to answer.

An interesting comment highlighted the balancing act that a trainee psychologist is often faced with, which is when to follow the client's lead and when to follow the process and structure of the interview. It seems to be an ongoing challenge to balance the task of building the working alliance and gathering a full history and when one is perceived as being more important than the other.

Participant 7 (female): I think it's relevant always and I think rapport is really important in questioning, however, when it comes to certain presentations in front of you, you have a certain obligation as to whether this person is able to provide you with truthful and responsible account of what it is that you want to know and not just something that is going to end it, the topic.

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Participant 10 (male): Yes there has to be a sense of trust and comfort they can then speak to me, they don't judge me they don't perceive me as anything different, but until you've reached that point it's very hard, there are risks.

The quote below is indicative of how aware the trainee psychologist is of the working alliance and that it is the relationship between client and clinician that influences disclosure, not the topic itself.

Participant 10 (male): It depends on the client, some clients are comfortable to speak about it some clients are not, I think it's more something I need to deal with than the clients, if the client wants to speak about anything irrespective of those aspects, they will speak about it even if there's a difference in age, gender, they have to trust you otherwise they just shut down.

4.2.1. Impact on the working alliance

Perception of self

Initially when developing this research project it was anticipated that the working alliance would be affected in some way during this section of the interview due to task related anxiety that trainees experience during the initial interview. However the emergent conversations seemed to indicate that there was a minimal impact on the working alliance and any discomfort experienced was the subjective experience of the trainee.

Participant 4 (female): For me now it [the discomfort] was the assumptions that I had, cultural and religious....

Participant 6 (female): I didn't notice anything again because I didn't ask it direct enough so there wasn't really an impact on the outcome except for creating a little bit of discomfort in the room and then quickly moving on.

Participant 8 (female): How would he view me in that moment, would he also feel why am I asking that? Why is that relevant? You're so young.

One participant felt that it is never an appropriate topic to inquire about as it is too personal.

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Participant 1 (female): For me I'm a very closed person, it's not something I will talk about to anybody so for me it is a bit of a challenge. So I don't want to talk about it so how can I expect someone else to talk about it, but I know it is something that has to be done ...

Perception of the process

Most participants felt that there had not been an impact on the working alliance which highlighted the fact that the discomfort and anxiety is an internal experience of the trainee psychologists. During the course of the semi-structured interview with the researcher some participants came to the realisation that their own anxiety and discomfort were the underlying obstacles to this segment of the interview with their client.

Participant 1 (female): I think it made it awkward and tense [the working alliance] for that moment but after that he was open to answering things. I think it was just to get over that bump and carry on and then it was fine.

The participant expressed the sense that it was a task that she needed to get through and cover the areas of inquiry that were necessary.

Participant 8 (female): You just want to get that interview done, get all the information, your supervisor needs to see it, quickly talk about it and move on.

One participant expressed some uncertainty about covering the topic of sexual health. Although he was familiar with what to expect from the process of the interview, the inquiries around sexual health were daunting.

Participant 10 (male): Looking at the list was fine but that question was like red!!! You're prepared for every other question except that one, everything just falls flat...very challenging. .

Personal Reflections: *Initially many of the research participants felt uncomfortable with the topic of sexual health. They were all familiar with the process and what was required from the interview. The content and managing the topic of sexual health was what I perceived as causing some discomfort. However, I framed the topic as being another interesting area of enquiry and attempted to chat about the topic in a conversational manner which seemed to put most of the participants at ease. Due to my own perception and understanding of the relevance of sexual*

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health I am at ease with managing the topic and did not feel uncomfortable during the interviews. It is my sense that me being at ease with sexual health vocabulary and content assisted most of the participants to experience this ease of the conversation and by the end of the interviews many were using terminology more easily than they had in the beginning of the interview. This confirms much of what the participants commented on that it was their own discomfort that affected the process and their clients. The more relaxed and comfortable the participant was with the topic the less perceived discomfort in the client.

4.3. Obstacles to emerge: Contextual factors

4.3.1. Family background and societal norms

An important factor to emerge from this study was how the family context and society as a whole has a profound impact on the beliefs and ideas the trainee psychologist has in terms of a conceptualisation of sexual health matters. Familial and societal norms as well as general discourses around sexual health appear to impact the trainee psychologist's ability to broach the topic of sexual health and manage it with either ease or discomfort.

Participant 5 (male): So in my social circles I am taught not to speak about it and my client also is taught not to speak about it socially. So it's two different people who socialise in the same way not to speak about that, they are now forced to speak about that, so when it comes to asking the question we are at a bit of a loss.

Participant 1 (female): For me it is a private thing, in my background just growing up it was very closed about all this sort of thing, so I feel that way as well. So how can I expect someone else to disclose all this information[sexual health information] to me....

Another participant acknowledged how society and one's family impacts on how she has made meaning of discussing the topic of sex, and who has the rights to speak about certain topics.

Participant 9 (female): I think it's society, it definitely plays a role in it [the ability to speak about sexual health] because it's maybe how we've grown up, not to keep it a secret but not to speak about it so openly, or that could just be me.

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The quote below illustrates the trainee psychologist's awareness of how his own beliefs influence his ability to ask certain questions as well as his ability to discern which topics are more relevant than others.

Participant 5 (male): ...but your own conviction and beliefs of what is right and wrong makes you feel anxious about asking these questions.

Participant 1 found it difficult to discuss sexual health within the research interview and struggled to articulate herself. She felt particularly uncomfortable when raising the topic of sexual health with a client and believes it is closely linked to her upbringing which is echoed in the following comments .

Participant 1 (female): In the home it [sexual health] was discussed once and that was it. Even when it was discussed at school I hated it, that was just my personal feeling.

Participant 8 (female): ... for myself who is not comfortable speaking about it because of my upbringing... I wasn't socialised to just bring it up, I didn't know how to so in that regard I did find it quite challenging.

Participant 3 (female): Yes it [sex] was discussed, it was more in the way of 'let's discuss this book', it wasn't very open it was all a matter of fact. There was one instance reading a newspaper about an incidence of rape and I asked my mother 'what is rape' and she said to me 'where did you get that word from'. I can't remember how she explained it but she wasn't freaked out about it I only remember asking her what it meant...it was not a taboo subject.

In some homes the topic of sexual health was avoided completely or was limited to the bare necessity of covering the topic.

Participant 11 (female): I was not told about sex at all and I don't think that is a good thing. I think children need to be told properly, what the act is, the consequences, the risk. I was an example of that - I had my first sexual experience and fell pregnant. I am comfortable with my sexuality now.

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*Participant 5 (male): **OMG** [oh my gosh] no never, absolutely not there is no discussion around that, no one talks about that, even with your older brothers and older sister there is just no discussion.*

Participant 2 (male): Basically yes [it is the way he was raised], that's how it is in my family, we don't talk about it....sensitive stuff like that. There's no like formal talk, my dad just once told me this....that if you have met a girl...you have got to grow up safe. He didn't even use the word 'sexual', like mention anything, just brief

Participant 9 (female): No, my Mum told me about puberty and stuff and that was an issue for me because when I got my period for the first time it was weird and I didn't even want to tell them and sex, she glossed over it which was weird, I don't know if that's just how they are. I think now that I'm older my Mum will make funny jokes about sex but it never was discussed, I always felt awkward about that stuff and perhaps they felt the same.

Participant 10 (male):... parents do not speak about sex.

The quote below illustrates a discourse within society regarding judgment and the sexual activity or number of partners an individual has. This sentiment is echoed by more than one participant. It is interesting to note that both the following comments were made by male participants.

Participant 5 (male): Their number of partners they have had in the past, it's quite embarrassing, it could be 10 partners so it labels you as this loose person and if I had to disclose this to you I stand the change of being judged. So I think a good working relationship, trust, comfort is essential.

Participant 2 (male): I think that they would feel that I am judging them, if you know what I mean, you know like that whatever they say it would be putting it in a way that was socially acceptable.

4.3.2. Gender

The differences between the genders is implicitly understood by most of the trainee psychologists yet there is a struggle to articulate accurately what these differences are regarding discussing sexual health. These implied rules appear to dictate what activities are deemed

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permissible for each gender as well the appropriateness of discussing sexual health according to gender.

Participant 2 (male): Talking to a female it's like crossing a boundary.

Participant 1 (female): I just think people generally get together when they're near similar ages, so this is going through my mind, not that I have any expectation to date the client.

Interviewer: So is it the expectation that if you're talking about sex that he might think that it's an invitation.

Participant 1: Yes, I think it's me and how I have grown up and how I've learnt things to be.

Interviewer: And how is that? How have you learnt things to be?

Participant 1: Me and my family environment and my friends, nothing specific.

Interviewer: Is it gender roles?

Participant 1: Yes I suppose you can say that.

Interviewer: That maybe it's difficult for females to talk about that kind of thing?

There is a general sense that it is easier to engage in a conversation about sexual health within the same gender and does not pose as much of a threat or risk as it does when discussing the topic with the opposite gender.

Participant 2 (male): But if it is man to man then that wouldn't be as much of a problem because you could just talk about it, whatever they are experiencing. ... Because maybe as a male to male we can like relate because we've got the same sort of opinion. I mean this is generalisation but....because as guys we would have the same kind of opinions and ideas about sex and obviously that differs greatly from females so with a male there is that sort of connection before. So it's more familiar, it's easier for us to, there's the same knowledge.

Participant 1 (female): Probably I think basically because it was male so it was just that much more uncomfortable, but I know he is straight and has a girlfriend so it wasn't like crossing boundaries.

Participant 5 (male): ...being a male and asking a female it just makes it uncomfortable.

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The powerful discourses and beliefs attached to gender and sexual health is accurately described by a participant who expressed shock at her stereotyped way of viewing sex in relation to gender. During the interview she expressed her horror at these limited views related to the topic.

Participant 11 (female): With a man you don't want to feel like you are crossing boundaries...

Interviewer: What are you concerned about?

Participant 11: Um ...asking things that are not going to be offensive

Interviewer: You don't feel that asking around other sensitive topics is offensive? They don't seem to hold the same energy as sexual issues?

Participant 11: Recently there was a man in the hospital...at my placement site. He was paralysed from the waist down and I felt so sorry for him...I was so uncomfortable to see him there...you know...not being able to...have sex. I almost thought for a second... it would have been better if it had been a woman.

Interviewer: What was it that made you feel uncomfortable?

Participant 11: I don't know...it's weird, but as a man...you know men, they have girlfriends...I can't believe I am actually saying this...but

Interviewer: Do you feel it would not have been as bad for a woman to be paralysed? You don't think you would have felt sorry for her no longer being able to have sex?

Participant 11: No...I don't know why but a man needs to have sex to be a man. A man kind of equals a penis and equals sex. Women ignore it...and hope it [sex] will go away.

Closely linked to the conversation above, one participant felt more at ease discussing sexual health with a male client due to the commonly held belief that men being more sexual will engage in the topic more easily.

Participant 7 (female): My personal opinion, I find that question to be much more easily asked to males, I'm not sure why, but I think they are much more open to talking about their sexual lives.

The beliefs related to gender and the implicitly understood rules of engagement are so forceful and prevalent in the therapy room that one participant's homosexual orientation was less of a threat to the therapy process than was the heterosexual-rules-of-engagement discourse.

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Interviewer: Because sexuality can sometimes be taboo to talk about as you said with this man, being the same age, it becomes awkward so what about it that makes it awkward?

Participant 9 (female) : Well that's quite weird to tell you because I'm gay so it was weird for me because you would think that it would be the opposite,, because you would think if I was asking a female it would be awkward but I think because he was a white male.

One participant succinctly summarises the findings of how the obstacle of gender invades the therapy setting:

Participant 5 (male): Well I think when you look at it, it shouldn't be difficult but for me I can relate to a male there is less discomfort I think it's just cross gender followed by society but it shouldn't, there are things that you shouldn't discuss with females and things you can discuss with males.

4.3.3. Age

An important factor that creates a significant obstacle to the gathering of sexual health information is that of age. This sentiment is illustrated when one participant describes her difficulty managing questions around sexual health. Her discomfort seems closely linked to her context and her relationship with her father and how this impacted on her feelings towards the appropriateness of the topic of sexual health. She struggled with the topic due to her perception of age and how that factor dictates which topics may or may not be appropriate to discuss, mediated by age.

Participant 6 (female): ... but for me it was very uncomfortable because he [the client] was the same age as my dad and for me it was as if I was asking my dad [about his sexual health] so it made it incredibly more uncomfortable for me.

Interviewer: So again age is now an issue on the other side of the spectrum, what is the assumption there? You being younger and this man being older?

Participant 6: It relates to the whole thing as seeing him as the same classification as my dad, I wouldn't just go to my dad and start asking him about his sexual history or anything like that, and it's never been something that him and I have ever spoken about I don't know how to initiate a conversation with a man in his late forties, fifties because I have nothing to draw on.

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A dominant discourse to emerge is that there is a commonly held belief that older or aging adults do not engage in sexual activity.

Participant 5 (male): If I see a 24 or 25 year old male it will be very much easier to discuss this, we are more or less the same age we do the same things we share the same preferences mostly, but if I see a 78 year old, this is a problem... we [people from his cultural group] have a huge belief when you get older sex is something you don't have any more, it shouldn't happen, older people shouldn't have sex, even if they're married, it's nasty.

Conversely there was one participant who felt that discussing sexual health with an older client would be easier due to the client having more life experience.

Participant 6 (female): they [older clients] come to terms by themselves and they are more comfortable with their own sexuality to some degree but more so with talking about it, it's normalised because they're older.

When a client is younger than the trainee psychologist there seems to be less concern when engaging with the topic of sexual health.

Participant 11 (female): My client was ok...he was younger[than me]. I think if he had been older it would have been more uncomfortable.

However many participants struggled with broaching the topic of sexual health when the client was of a similar age to the trainee psychologist.

Participant 1 (female): ...he is a similar age to me, I felt uncomfortable and I think he did as well because he had this nervous laugh and didn't make eye contact with me, he looked away, so obviously he was uncomfortable and for me on my side as well, I don't know if it was me or because of his reaction I felt uncomfortable.

Participant 9 (female): I think it was gender but also age, we were the same age and white, I'm mixed, I'm white and Indian but all my friends are mainly white so having a white male, it was almost personal, so he could have been a friend, I have had a white male before but he was quite

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old, about sixty, and he was quite open with the sexual history and that wasn't as awkward as this, I think it was more the age than the gender.

4.3.4. Power ratios

There are a number of ways in which the balance of power may shift and change within the therapy setting. Usually the power is by default, with the therapist, based on commonly held ideas relating to professionalism and expertise. As a trainee psychologist one of the experiences that came to the fore in this study seems to be that as a trainee psychologist one does not have the right to ask certain questions due to not yet being fully qualified.

Participant 7 (female): I think the problem was that I didn't have the right to ask the question ...and also it was difficult to talk to someone that was brand new to me about something that is such an intimate part of their lives.

One participant felt that different factors determined who held the power within the therapy room and that this influenced the ease or discomfort the trainee felt and whether it was possible to raise the topic of sexual health.

Participant 5 (male): I think it was more comfortable to have this power... for the older client it's like ok you're not a child so they have more power but if you're dealing with a young child you have more power over them, I can ask this any way I like so with a child you have more power.

Yet another power ratio to emerge was that between genders and one participant, although well versed in sexual health matters, felt that she may feel threatened if there was a dominant gender discourse present.

Participant 3 (female): I think what maybe concerns me, which I haven't come across, not cultural differences but more power differences, perhaps if I had a male that used sex as a means of power I think I might find that difficult, the only reason I would find that difficult is because I worked in the sexual assault unit. Yes I think that's the difference, I'm not talking about in a particular culture, just if there was a power dynamic came into it...

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Echoing similar sentiments, a male participant describes being acutely aware of a client who gives the impression of dominating the balance of power in terms of gender discourses. This male participant was alerted to the client's sexist ideas and it caused discomfort.

Participant 6 (female): The feeling I got from him he talks down to women. He does not have good things to say when he describes women .

Age creates a further power ratio and impacts the trainee psychologists ability to manage the topic of sexual health. The commonly held rules within cultural groups dictates which generation is permitted to discuss the topic.

Participant 10 (male): Yes it is taboo because there's always this difference in power, they were elders/adults and I was never going to ask this, to someone my own age I could ask it, not to a child because they would tell this to their parents and they would wonder why I asked this, because they don't speak about this, so I'm assuming this is how they grew up in our culture, so if I had to ask it in Zulu it would be new to them, why is this guy asking this, what's he trying to do and then they wouldn't come back to me so if there was a way of putting it lightly, maybe, I'm not saying I would.

4.3.5. Culture

Despite South Africa being so diverse in terms of cultures, this factor did not seem to pose as great an obstacle as may have been supposed. A few comments illustrate that the trainee psychologists are aware of the possibility of having to face challenges in the therapy setting due to cultural differences. Most however did feel able to deal with these challenges in a multicultural setting appropriately.

Participant 5 (male): I have had white clients, so it's not really the culture per say it's more the age.

Yet another participant describes how having a multi-cultural social group has assisted with feeling more at ease and better equipped with handling cultural differences.

Participant 8 (female):because with culture you can more or less have an understanding of culture, you have friends from different cultures so you know how they do things.

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At times participants did experience moments of doubt and caution due to cultural differences however this factor did not appear to be as invasive as gender.

Participant 5 (male): If you think of it from a cultural perspective and the clients we see, there are cultural intricacies, if you're seeing a black guy there a lot of things on sexual stuff so how are they going to interpret all this stuff, how comfortable are they, most people are not really open for that, and being a male asking a female it just makes it uncomfortable.

This participant makes an interesting point about conservative cultures implying that it is not necessarily a challenge in a few cultures and not in others, rather it is an obstacle for all cultures if there are conservative and restrictive ideas related to sexual health.

Participant 5 (male): I think so in most conservative cultures the whole sexual matter is not spoken about, it's something you don't speak about at home, you just don't talk about it so it becomes a huge difficulty to talk about this to a stranger so in my social circles I am taught not to speak about it and my client also is taught not to speak about it socially, so it's two different people who socialise in the same way not to speak about that, they are now forced to speak about that, so when it comes to asking the question we are at a bit of a loss.

One participant seems acutely aware of the implications of cross cultural encounters, however, it appears she is thinking about many factors she has to manage within the therapy setting.

Participant 9 (female): Culture has a lot to do with it for me, not that I'm racist but it's a reality, it definitely was his race his age and his gender that played a role when I asked those questions, definitely.

One participant recognised how his own cultural heritage influenced his understanding of the topic and the ability to engage in the topic of sexual health.

Participant 10 (male): Because you grow up being told not to speak about that, you just don't speak about it, it's cultural, when you speak about it people perceive you as being forward so even in therapy I sit there and think they will perceive me as being forward and perhaps never come back so it's one of the questions I keep aside.

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Of significance a participant struggled to articulate why she may find it easier to speak to a black male than a white male about sexual health. She describes herself as being half Indian and half White yet felt uncomfortable to discuss sexual health with her white male client, perhaps alluding to racial discourses within South Africa and closely connected to power ratios and the difficulty in articulating and confronting these issues.

Interviewer: So tell me what it would be like had he been black?

Participant 9: I don't know actually but I know maybe it would be a bit easier.

Interviewer: And why?

Participant 9: Maybe it wouldn't be because I also have black friends, maybe it's the male and not the race, maybe it's the age. But perhaps I would feel just as awkward even if it was an older person because I'm so young, I'm asking them about their sexual history, so it's about how I feel as to how they will feel me asking these questions, I'm this youngster asking them all these sexual questions.

4.3.6. Language

Another obstacle faced by the trainee psychologist was that of language. This factor is multi-faceted as it not only highlights the differences between different language groups but also the differences and struggles within the same language. The challenge seems to be related to choosing the appropriate words in order to gather the information needed as well as to keep the conversation open and not to close it down with the client.

Participant 9 (female): Because we've been speaking so much I feel that I don't ask enough actually. I just go through it so maybe I should. I would still use the word 'intimate' but I think I should rephrase when they ask me to clarify - tell me about your sexual activity? I never probe enough, I assume things.

Language differences between different languages can pose a great challenge for the trainee psychologist.

Participant 5 (male): They [language differences] are very prominent especially when you speak about language, when you're working with a client that can speak English very well it becomes a less anxious process to speak about sexual functioning, if you speaking to a client that speaks

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Zulu it becomes a really different process. The words, you can't find the right words to ask about sexual performance... Because the words we have in a way are very direct there's no sugar coating, so using English is much better, using Zulu words will be quite difficult.

Participant 10 (male): I think it's a language barrier, we speak in English, we know what to ask in English, we're taught to ask in English.

Interviewer: So were you conducting this interview in Zulu?

Participant 10: Yes in Zulu, you do not know how to ask in Zulu it will never sound the same, Zulu is much deeper, so I was thinking how do I ask this.

Interviewer: I would really like to know about this as you are the first person to bring language into this, very interesting for me. So in Zulu, you said it's much deeper.

Participant 10: In English there are so many indirect ways of putting it, in Zulu it's direct and it's just going to sound so bad.

The challenge of having an adequate vocabulary to draw on is highlighted in the following quote:

Participant 9 (female): My number one was using the word 'intimate', no sexual activity no sexual intercourse, that was my number one to help me, it's easier to say.

Interviewer: This is interesting because we do choose certain words, so 'intimacy' helps you.

Participant 9: It makes me feel more comfortable with it and also using the marital history as a gateway to speak about it, obviously not everyone is married, the words, your relationship, as a warm up before going into sexual words.

The following quotes indicate the struggle to find the words to use and how to phrase the question.

Participant 6 (female):asking it but in a soft manner

Participant 10 (male): I would try and ask you about your 'sexual activity', I wouldn't know how to, I would rather not ask it

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Participant 4 (female): ...you pick up on those cues, as a married woman I refer to my husband as my 'husband'. If I'm speaking to someone and they speak about my 'partner' I pick up on this, so there again it's about language, language gives away so much.

Participant 6 (female): . I tried bringing it up with him and again it didn't go well because I was not direct and to the point and I had asked him if anyone had violated him in any way, physically. Any way ... and I don't think he understood what I meant...

Due to a very limited conceptual map concerning the topic of sexual health and a vocabulary related to the topic the following participant describes the inappropriateness of his chosen words and how they caused discomfort and self-doubt.

Participant 5 (male): For me it was a problem I finally had to ask: do you feel like having sex. I immediately felt "what did you ask that for?"... I'm a male you're a female so do you feel like having sex, for me this was not the right way to ask, for me I have not found the correct way to ask about that especially about the sexual functioning, the sexual partners.

4.3.7. Religious beliefs

Although religion did not appear to be particularly problematic for the trainee psychologists in this study there were a few comments which highlight possible areas that may pose challenges for the therapist. The following comment illustrates internal struggles the trainee psychologists have in terms of understanding their blind spots in relation to religious beliefs.

Participant 5 (male): I think the discomfort there, being a Christian myself, I have my own convictions around sex and sexual intimacy so when you look at discussing issues with a person who's married and having sexual intercourse, it becomes difficult because you have your own judgment about premarital sex or marital sex, so you have all this discomfort in yourself as well.

Another participant had similar thoughts and challenges regarding this line of questioning:

Participant 8 (female): ... being raised in a Catholic home and the golden rule was to abstain it just went against my religion, especially speaking to someone who was experienced, I wasn't, same age, it was quite challenging in that regard.

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Although the following participants had limited experience concerning discussing sexual health, for her it was closely linked to religion and her beliefs which dictated that sex was a taboo subject to talk about.

Participant 6 (female): It definitely makes it difficult, it's never been an open topic and this is largely because of religion, my mother was always open but there was always the sense that although she was always open you just don't talk about it, so that's why for me it is always uncomfortable because it was not something I was used to talking about openly.

Participant 7 (female): I do find it difficult to ask this question of males or females of my own faith because it's not something we talk about, not that it's taboo, but it's not something you randomly talk about and probably being a Muslim girl asking a male or female this question I find it can be anxiety provoking.

A participant described how her own assumptions about a client's membership of a certain religious group, influenced how she made decisions regarding which topics to raise and which topics to ignore.

Participant 4 (female): The assumption was that this was going to be difficult because this woman is not going to want to talk about her sex life really with her husband. From the beginning I knew he was very controlling and she didn't have much say in her day to day life even in terms of her beauty regime, if that's the right word, and it seemed very controlling. So yes the assumption was that she really doesn't speak about this at all.... The assumption with regard to the religion... that it doesn't encourage or allow for that open conversation.

4.4. Strategies employed by trainee psychologists when faced with obstacles

4.4.1. Avoidance

It would seem that there are a range of factors such as inexperience and a limited word bank to draw on when discussing sexual matters and these may contribute to the strong desire to try and avoid the topic of sexual health. This sense is succinctly expressed by Macdowall (2010) in the following quote in relation to discussing sex within therapy: Fear of 'opening up a can of worms'

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(Macdowall et al. 2010) . It was found that many of the participants would avoid the topic of sexual health completely if they could.

Participant 1 (female): Yes I would [avoid the topic].

Participant 5 (male): Definitely I would [avoid the topic].

Participant 7 (female): I avoided it up until the very end, the irony behind it is that client is like the 99% of the other clients I was talking about where I could have asked her half way through the intake and would have had no problem with it based on her response, because by then a good rapport had been established, we had a good vibe, but because of my own anxiety I put it off right until the end, we were trying to avoid it at all costs but eventually we got to it.

Participant 10 (male): ...if my supervisor tells me to ask it then I will ask it but if not I just go past it.

Due to a lack of experience with managing the topic of sexual health one participant repeatedly avoided the topic of sexual health although the client had mentioned that she had been sexually abused. The participant describes feeling overwhelmed with self-talk and uncertainty regarding how to approach the topic without causing harm to his client.

Participant 2 (male):... I mean she has had sexual abuse and sexual history so it has to be important surely, I felt like , I mean if you think about it logically.....And although she has had sexual abuse it is very hard to see how that affected her from there to now. And I still don't know how to bring it up, like current life, childhood, how that affects sexual life and if it did.....

Due to subjective discomfort one participant felt that the risk of asking questions about sexual health was too great and therefore deliberately would ignore the topic.

Participant 10 (male): No, for me the risk outweighs the benefits, for me, so no just put it aside...It was as if it [the topic of sexual health] wasn't there.

Deliberately avoiding the topic may be connected to feelings of inadequacy and a lack of experience concerning the topic of sexual health, a sense of naivety. Due to the complexity of

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the topic the trainee psychologist may feel afraid and uncertain of how to manage these complexities.

Participant 6 (female): it's not a crucial thing unless they're being sexually abused.

4.4.2. Restrained ability to enquire about sexual health

It appears that a common strategy employed by trainee psychologists was to rush through this part of the interview when asking general questions concerning sexual health. The process of the interview schedule requires this content be covered and many participants felt it would suffice to ask one or two questions about sexual health and then move on to other subjects the trainee psychologist felt more comfortable with. Therefore the process requires general enquiries followed by specific probing when appropriate. However, the trainee psychologist appears to struggle with anything more than asking a brief, general question before changing the topic or line of questioning.

Participant 1 (female): I just move onto something I am more comfortable with.

Participant 2 (male): I asked 1 question, saw that it was fine and then moved on

Participant 5 (male): I think that I just breeze through it and never dwell on a question [in this segment of the interview] and move onto the next question...

Participant 6 (female): So it's easy then to dissipate that discomfort by just changing the topic, you quickly move on and it goes out the room.

One participant struggled to find the right words to use and so she describes having the sense of needing to cover the topic of sexual health, being ill equipped to do so and briefly touching on the topic.

Participant 8 (female): I would have to look at my page, almost like a crutch to settle my nerves and my anxiety, just to write down the key points and then go into the question of ok you're in a relationship when did you start getting intimate and I would try and skirt around the topic.

Participant 9 (female): I feel like I tend to, once I have an answer I go off of it, I don't probe anymore I think because it's a bit awkward.

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Participant 10 (male): Yes very quickly, even when I picked the paper up afterwards I felt ok it's done, if my supervisors ask this then I'll go back.

4.4.3. Employing a medical paradigm

The strategy of employing the medical frame and of using the clinical format of the interview schedule alleviated some discomfort when asking about sexual health. As stated by Macdowall (2010, p. 334), using the medical frame helps one to normalise the need for asking about sexual health - "Oh this is on the sheet of questions to ask so I have to ask you". The positioning of psychology within a medical paradigm and the structure of the interview schedule reinforces the idea that sexual health can be understood as a medical, biological process. The medical framework therefore guides the trainee psychologist in using questions seeking out a medical understanding in terms of functions, pathology and symptoms.

Participant 2 (male): When I asked about sexual functioning I asked about libido levels. ... we are looking at normal behaviours or compulsive behaviours.

What emerges is that feeling comfortable with asking questions about sexual health is perpetuated by the understanding of sexual health in terms of symptoms and not a nuanced understanding of sexuality and sexual health as being more complex and indicative of other areas of distress, not only within a medical understanding. Sexual health is a dynamic subject and therefore cannot be looked at from a perspective which detects an absence of a symptom only as indicating health. The subject of sexual health encompasses illness and non-illness states, from biological to psychiatric as well as being indicative of emotional or relational challenges. As highlighted in the following quote the search for understanding through symptoms is a protocol followed during the interview.

Participant 10 (male): Yes I do understand, it's important because if someone has been in an abusive relationship, sexually assault, molested, it will play a big part in making a diagnosis...

Creating a context for change through co-constructing and expanding the choices for a client based on the exploration of different possibilities and moving beyond pathologising descriptions of their lives and relationships (Markovic, 2013).

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Participant 7 (female): ...although intimate and personal [asking about Suicidality and homicidality], the forensic history of had they been arrested, that is important to my practice. Had they been sexually active in a normal sense, that had nothing really to do with my practice.

It appears that the ability to inquire about drug or alcohol use is closely linked to understanding these concepts with a medical frame, investigating symptoms and aiming at diagnosis. Inquiries about suicidal ideation appear to be understood within this framework and can be understood in connection to signs and symptoms and possible diagnosis.

Participant 1 (female): [There isn't an issue with drug abuse and alcohol when you bring it up] Yes that's right.

Participant 5 (male): With those sensitive topics I was able to ask about them, I didn't feel so anxious, drugs are a social problem, alcohol and smoking doesn't have much stigma ...There is not a problem asking about that but there is a problem talking about sex.

Participant 2 (male): I feel the same about suicidal ideation. I would only ask the question if the person had a history of depression but I would still ask it.

Interviewer: So you are more likely to ask about suicidal ideation and tick the box that you asked about that but not about sexual history and sexual functioning?

Participant 2: Yes

Interviewer: And do you think you would definitely always ask about alcohol and drug use?

Participant 2: Yes I would ask that every time.

Participant 7 (female): Yes probably it was intimate and personal [asking about suicidal ideation, alcohol and drug use] but there was quite a psychological background as to why I was asking that question, so that was important to my work. So the forensic history of : had they been arrested. Had they been sexually active in a normal sense, that had nothing really to do with my practice

A participant explains the separate understanding and almost mutually exclusive understanding of gathering information and how a medical framework, although lacks a human connection, provides a justification and comfort to ask certain questions.

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Participant 4 (female): ...[speaking about an experience in the hospital] and I went through the entire history in about 40 minutes and it was just cold and clinical and to the point: asking are you sexually active, how many sexual partners, did you use protection? I just ticked the box, move onto the next, whereas if I think about it in a clinic or in a therapeutic setting that's when the hesitance comes in.

Furthermore a participant explains her understanding of why she asks questions about sexual health and it falls within a medical paradigm.

Participant 6 (female): Sexual functioning: one reason, why is it sometimes diagnostic, and sexual history - it is also quite important to understand whether there was any abuse, how early did they initiate any sexual activity.

4.4.4. Personal development through self education

According to Kingsberg (2004) there is a lack of training and an urgent need for more in-depth training in human sexuality across the lifespan in a richer understanding of human development. It appears that the trainee psychologists who were more comfortable with dealing with the topic of sexual health had explored and questioned their own assumptions and discomfort regarding sexual health. Knowledge allowed more ease in navigating a way through sensitive topics such as sexual health. The more exposure an individual has had, it stands to reason, as indicated in the quotes, that it becomes easier and more comfortable to handle the topic of sexual health.

Participant 1 (female): ...I would have to do my own research and reading [about the topic of sexuality and sexual health].

One participant had worked at Child Line for a few years and through exposure had become familiar with being required to deal with the topic of sexual health and sexual abuse. She had made a conscious effort to educate herself and extend herself further.

Participant 4 (female): ...I think as therapists we should constantly try and improve and develop on those life skills and I think even just now I'm realising that as much as I thought I was doing that, you can still do more of it. You can still prepare yourself more, you can still expose yourself more and learn how to deal with even the difficult or assumed to be difficult situations.

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The following comment illustrates the importance for a trainee psychologist to locate their own subjective discomfort and extend their own knowledge around topics that cause unease.

Participant 7 (female): No it wasn't from training it had to be my own comfort to ask the question and hide my anxiety around asking the questions around sensitive topics.

4.4.5. Normalising

At times when the trainee was able to feel at ease with the topic of sexual health and be able to normalise the subject it seemed to enable the client to move through the awkwardness felt when talking about sexual health.

Participant 3 (female): I didn't expect that reaction [of showing surprise] but I think the client realised it was not uncomfortable for me so she was able to carry on which is very important.

Participant 8 (female): I'll find a way that I'm comfortable enough to talk about it but also to be genuine, go into it with a sense of curiosity as opposed to being very fearful of it and just make it like a conversation and I think most people are open and honest. Also checking with the client, where are they?

Participant 8 (female): Peers support is important because you're in it together so being exposed to it and getting practice because I would not have known I was uncomfortable if I hadn't done it, so role play was a good thing but more focus on the debriefing part of it would be helpful.

Personal Reflections: *My intention, when conducting the research interviews, was to position the conversation about my research into sexual health as if it was a normal and acceptable conversation, just as any other topic may be. Each interview began with the sense of things being a little awkward and some participants were uncertain regarding how to talk about sexual matters. By half way through the interview each participant had become visibly more comfortable with the topic and by the end of the interview there appeared subtle shifts in levels of comfort with the topic. I had the sense that the conversation had in some way promoted more self-confidence and ease to further their own exploration and education into sexual health topics.*

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4.4.6. Retrospective and current life experience

A training program is developed to ensure that a trainee psychologist is taught core competencies. The scope of psychology is so vast that it would be impossible to cover all topics. It is through the ongoing involvement in the field of psychology and actively engaging in the therapy process that a broader repertoire is developed in each participant over time.

Participant 7 (female): ... the literature is helpful but I think only experience is the best help.

Life experience and relationships are ways in which trainee psychologists build their knowledge base and often it is this experiential learning that assists the trainee psychologist and will assist into the psychologists growth and development.

Participant 3 (female): ... I've probably been around and seen everything and heard everything especially having children that have gone through different experiences and now are older and having been through their sexual education, I definitely think it does.

Personal Reflections: *I feel that due to my age and the fact that I have been married for fourteen years and had many relationships with extended family and personal challenges that this experience has assisted me in discussing sexual health. In addition having three children has added to a wider repertoire regarding this topic.*

4.5. Looking to the future: in the words of the participants

A broader vocabulary for sexual topics and the opportunity to practice using the vocabulary around sexual health is required.

Participant 6 (female): So I think that I missed that aspect [talking about sex] it's difficult for me to now bring that topic up because I have nothing to draw on.

Participant 7 (female): First ask the questions you remember. Get yourself to vocalise it, hear what you sound like, record yourself so you're making sure of your tone and your pitch, so although you're panicking on the inside you appear calm on the outside.

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Participant 3 (female): I feel we should have done role play around the topic of sexual health, sexual history and sexual functioning so we can equip ourselves when dealing with clients as to why we ask these sensitive questions.

A broader understanding of the relevance regarding the use and usefulness of sexual health information.

Participant 3 (female): [Referring to training] I was thinking maybe to explain why it's necessary, I don't think we actually spoke about that...what are the reasons behind asking the questions on sex.

Opportunities to have discussions in a safe environment with the aim of challenging stereotypes and to explore the similarities and differences, as well as the social constructions of other cultures.

Participant 1 (female): I would say throwing us into the deep end, practicing on each other, confronting it head on and also more reasoning as to why we ask these specific questions.

Participant 11 (female): ...more workshops on sexuality and discussions with the class.

Participant 5 (male): I think the workshops are obvious not just sexual functioning but looking at the different cultures, looking at the different ages, looking at the different genders taking those, if you look at the South African population ... usually female, Indian, black people, looking at culture and the ages.

Understanding the importance of personal growth and to continue learning beyond the scope of a training program.

Participant 8: Yes my own personal paradigm. Not because I was forced to do it but because I'm the type of person that if I'm given a challenge I don't give up I will try to overcome it. I find that this is one aspect of my interview skills that needs work so I will try and improve in that area so I was more determined and confident but it was more my own personal paradigm that played a role. Theoretically... not really because it's not personal enough because I need to connect with the client.

4.6. The participants reflect back on the research interview

During the process of the interview it became apparent that many of the participants were able to recognise that much of the discomfort around this topic originated within themselves and not due to anything their clients had said or done. This highlights the importance of using semi-structured interviewing in a dynamic way which allows for exploration by both researcher and participant in a collaborative way.

At the closing of the semi-structured interview each participant was given the opportunity to reflect back on the process and comment on any points of interest which they wanted to add or discuss. Many had felt the interview had challenged or prompted further exploration of the topic of sexual health.

Participant 1 (female): It's more on me, I have to become more comfortable with it and with more time and practice it's ok to ask people about this, I think over time it will be fine, it's all on my side... to deal with my anxiety.

Participant 5 (male): ... it scares the hell out of me, that question. I have been able to ask younger people say even forty but when it comes to really older it is more difficult, I really have not found a way to do it or to alleviate my own anxiety.

Participant 11 (female): This interview has made me realise how many things I need to work on around this topic. I thought I was ok with this kind of questioning....

Participant 7 (female): I never thought about it [the topic of sexual health] until today, thought provoking stuff.

Participant 9 (female): ... I know there's more to the sexual history, there are different parts in brackets pertaining to sexual history, e.g. puberty, how did you find out about it etc. etc., I never do that because maybe I feel it's not relevant but maybe I should.

Personal Reflections: *Looking over the transcriptions numerous times I became aware of how many of the participants used the word 'it' instead of using the words: sex, sexual health or sexuality. I also fell into that linguistic trap and found myself relegating the topic to being 'it'! The use of the word 'it' reinforces the profound sense of how challenging it is to use words*

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relating to sexual health. The use of the word 'it' evokes in me a sense that we are discussing something alien or indeed something taboo that cannot be named.

CHAPTER 5

5. DISCUSSION

5.1. A Postmodern view

Traditionally therapists have been trained and educated in such a way that the expectation associated with the role of the therapist is to know the emotional and psychological 'truths' about their clients (Thomas, 2002.). This is not an indictment on the profession of psychology rather an awareness of the structuralist views commonly held. A structuralist view is based on the premise that there are "fundamental, unchanging structures" that underlie everything (Thomas, 2002.). The implication for the therapist is the underlying notion that it is possible, through deep exploration and the uncovering of the emotional and psychological truths of the client, to know the client and understand her struggles. This notion is held to be the guiding principle in an effort to help the client and in fulfilling a service which a therapist is expected to provide. By gathering a full history from a client the trainee psychologist endeavors to begin this deep exploration of an individual and to facilitate the trainee psychologist in getting to know the client. The process of the first interview is semi-structured so as to gather information understood as being pertinent to this exploration.

The postmodern view challenges the idea that there are any fixed truths and indeed whether an individual can certainly be understood in an individual sense. Truths as presented by an individual are "local" truths and not necessarily universal or objective truths (Burns, Goodman & Orman, 2013). The postmodern focus therefore is on understanding the individual within her context and the acceptance that an individual is socially constructed through socio-political discourses and multi-level interactions with others. Employing a postmodern view within this research project is an attempt to understand how a trainee psychologist manages sexual health content and what socially constructed framework informs the process. The postmodern framework may assist in understanding the trainee psychologists in relation to their context and in relation to current discourses around sexual health, and how these factors may impact the ability to manage with the sexual health segment of the first interview.

5.1.1. Understanding the paradigm shift

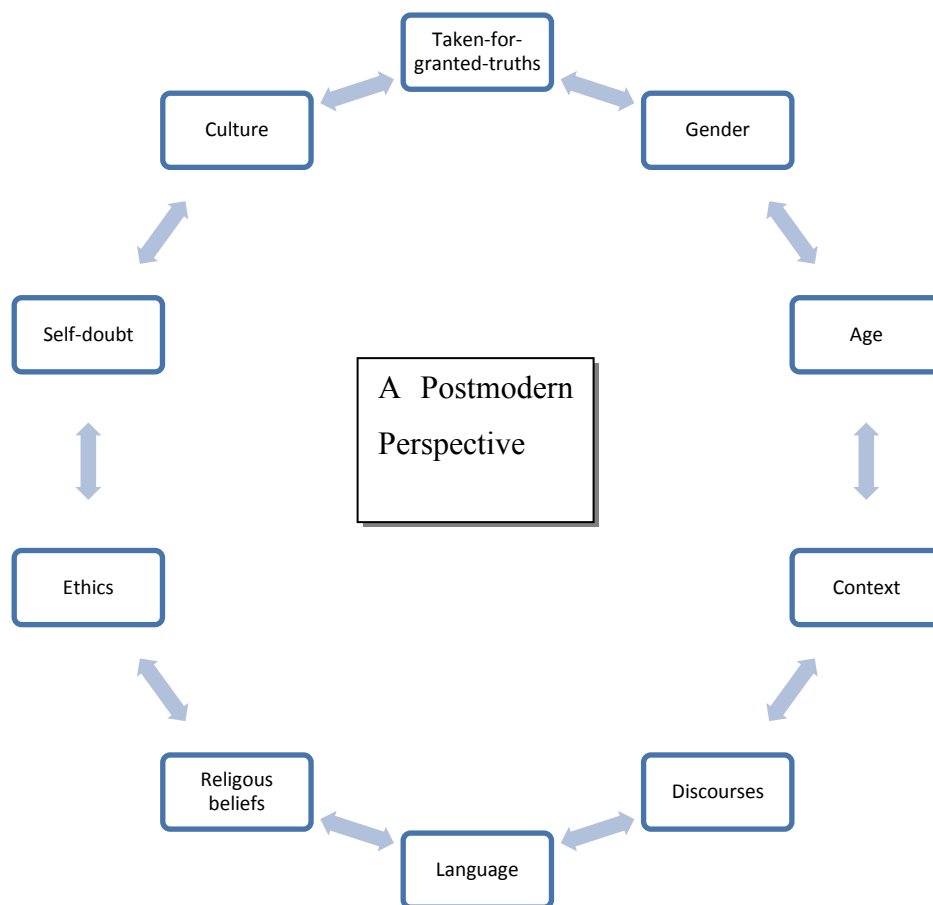
Although the structuralist approach has made substantial progress in understanding aspects ranging from universal concepts such as the cosmos to the most minute particles of the known world, the need to widen the lens to view people within their unique context propelled the postmodern shift. Diverse cultures and challenging socio-political discourses have fueled this need for an alternative view. Added to this shift is the move away from definitive descriptions of an individual and a move towards considering how the social construction of an individual influences the way in which an individual interacts and responds to others and to their social world. The emphasis is therefore that despite adequate training for trainee psychologists, the onus rests on the individual trainee psychologist to develop the ability to reflect on how she is socially constructed, how she comes to make meaning of concepts and how this construction affects the therapy process. The focus is thus on how those constructions assist or impinge the trainee psychologist's ability to manage the topic of sexual health during the intake interview.

Traditionally a common strategy used by many clinicians is to remain 'value-free' which posits that the clinician is able to leave her personal beliefs outside of the therapy room and to assume a non-judgmental stance. Challenging this, the postmodern view embraces the idea that it is this very awareness, the awareness of one's values and beliefs and that personal understandings are not objective and value-free that is paramount. The rationale is that to explore personal ideas and meanings is an imperative, due to the fact that an individual is a social construction and this is the salient feature of postmodern thought (Russell & Carey, 2004). Therefore, recent thinking challenges the concept of being value-free and instead beckons the clinician to be fully aware of her value and beliefs systems and how those may impact the process of therapy and the personal ethics which guide the line of enquiry during therapy. According to McWilliams (2004), a core skill for the trainee psychologist to develop is the knowhow of being able to integrate her personal style and her role as clinician. Hence a structuralist view and the structure of the interview may be an attempt to curtail the trainees' personal beliefs and provide a generic format. Yet the personal insight and acknowledgment of these beliefs may indeed be a panacea in confronting the challenges of different viewpoints between clinician and client and in dealing with ambiguity within the therapeutic context. During the training program it appears that

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trainee psychologists require the opportunities to develop this insight in relation to personal beliefs and how they have come to make meaning regarding sexual health matters.

Diagram 3 : Postmodern Perspective



5.1.2. The trainee psychologist within her context

The postmodern view therefore seeks to view the individual as part of her context which includes the structures, politics and power ratios that may be part of her context. She makes meaning in accordance to the interactions she has within this multi-layered context. In order to get to 'know' her it is therefore important to become more familiar with how she makes meaning of this context and her relationships with others (McWilliams, 2004). Furthermore it is important to explore how her context influences her and this process of meaning making. As presented in the findings section (section 4.3.1. p. 73) many of the participants in this study were acutely aware of how their social structures had influenced their meaning attached to the topic of sexual health. One participant describes this well as she shares her insight linking her personal context to the way in which she experienced and thought about therapy with a client. The following comment demonstrates how the current contexts of a clinician form her own thoughts and conceptualisation of a client.

Participant 4 (female): ... in the first interview we spoke about the three kids and she didn't speak about being pregnant and her birth and all of that in a relaxed open way. And as a side note, whether it was important or not... I was pregnant at the time so I obviously knew and from a personal experience how you have to talk about those things, think about those things, your body is going through all those things. She almost wormed around them, she was pregnant and had three kids, it just happened, the stork dropped them off and that was it, so the approach to having three kids was that the stork dropped them off.

Although sexual health and information pertaining to intimacy were discussed in some of the participants homes while growing up, it has emerged that more often than not it is done in the form of supplying facts and covering the fundamental facts only. In some homes the topic of sexual health was avoided completely as illustrated in the findings section (section 4.3.1. p. 73). Within families the topic of sexual health seems to be limited to biological discussions and there appears to be a strong sense of it being uncomfortable for parents to discuss the topic with their children. This not only reinforces the positioning of sexual health within a medical framework, it further reinforces the idea that sexual health is a taboo subject. As indicated in the literature review, science, biology and medicine have made numerous attempts over the course of time to

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demonstrate, in a mechanistic way how humans should 'position' themselves around thoughts of their body and how it works, as facts. What this science has failed to apply is that the logic based, evidence based positions hold less value when one has to address the make-up of something as dynamic as a human being. The chasm arises due to the fact that we are not merely a composition of the sum of our parts and that each individual interacts with these 'parts' in a biological, psychological, emotional and spiritual way, for example and that we make decisions of how we use these 'parts' in relation to the emotional states, religious beliefs and socio-political discourses. Hence mental health professionals are by default caught in the middle of the medical model on one side and the biopsychosocial model on the other. The implications are a deficit in developing the skills and vocabulary to adequately manage the topic beyond a medical understanding and a medical vocabulary.

Personal Reflections: My context has aided me in feeling more at ease with discussions about sexual matters. I was raised in a home where sexuality and sexual health was an ongoing conversation with my parents. Just as we had discussions about alcohol and drug use, political discussions, sex was another topic open for discussion. Being married and having three children has enabled me, through my relationships, to view sexuality as another part of me as a whole. Understanding my own experiences assisted me during the interview process as I was able to highlight how contextual differences form the meanings we attach to sexuality and the topic of sexual health. This was helpful in engaging in a conversation with each participant about the uniqueness of our views which are influenced by our individual contexts.

5.2. Taken-for-granted-truths

Taken for granted truths are understood to be discourses and ideas that are commonly held to be true by the majority of society (Russell & Carey, 2004). Some of these ideas may for example be around issues of class, race, gender or age and they are ideas that are passed on from one generation to another without being questioned. This is illustrated in the quotes found in the findings sections (section 4.3.2. p. 75), showing how talking man to man, a commonly held idea, is easier when the subject is sexual health. According to Rarick & Ladany (2012) an individual's biological sex has little to do with how one may think or feel about gender-related topics. However, it seems that there are commonly held discourses relating to gender and certain

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qualities associated with each gender. Age old ideas like 'boys don't cry' or 'sit like a lady' permeate many levels of society and influence how boy and girl children are socialised. Previously some research has equated gender attitudes with biological sex (Rarick & Ladany, 2012). This reinforces many taken-for-granted-truths linking qualities to a particular gender.

People and taken-for-granted truths are intricately interwoven and it may be difficult to separate the person from the context which is why it is paramount that the individual is viewed within her context. It is important to develop insight through reflexivity, into taken-for-granted-truths in order to have a broader understanding of how a trainee psychologist may be influenced in her line of enquiry and feelings of discomfort within the therapy setting. A commonly held belief and one of the vestiges of a patriarchal society is that a woman who enjoys her own sexuality is often viewed as 'bad', 'loose' or having 'no morals' (Orbach, 2009). This sentiment was highlighted in comments made by participants alluding to the idea of loose morals in relation to women who have a few sexual partners (section 4.3.1. p. 75)

One participant had grown up in an orthodox religious home where the taken-for-granted-truth of the family and the religious doctrine rests on the idea that sex is only sanctioned within the confines of a marriage. This made it acutely uncomfortable for her to raise the topic of sexual health (section 4.3.7 p. 84). Yet another belief which emerged strongly with many participants was the commonly held idea that speaking about sexual health with someone of the same gender is easier in comparison to the difficulty experienced when the client is of the opposite gender. The take-for-granted-truth seems to be that all men have certain similar ideas and understandings about sexual health and these differ from the understanding that women have about sex. The topic of sexual health and raising it in conversation seems to have many rules attached to it and to imply certain beliefs. The taken-for-granted truth seems to be linked to the ideas that if a man initiates conversation about sex he is sexually interested or aroused by the woman he is speaking to, implying a predatory quality associated with men. The commonly held idea about a woman initiating this line of questioning appears to be that she may be deemed as being too forward and not fit the demure idea often held to be associated as a feminine quality. Sanders and Tomm (1989), cited in Markovic (2013), emphasized the importance of therapist's awareness of their sexual values, attitudes and blind spots, particularly their blindness to patriarchy (Markovic,

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2013). Media discourses that have attempted to debunk this stereotype of gender based understandings of sexuality, such as the movie *Sex in the City*, has had the desired response of disgust from 'morally virtuous' people in society on the one hand, and on the other hand pure intrigue and curiosity from those willing to question their own belief systems. This amplifies the need to allow trainee psychologists the opportunity to explore their blind spots and challenge taken-for-granted-truths which are insidiously present within every sphere of life. These opportunities need to be made available within a training program, guided and facilitated by lecturers and supervisors.

The following quote has been placed here as it is a wonderful example of how taken-for-granted-truths are present on many subtle levels:

Participant 9 (female): ... maybe married people because you would assume they were having sex.

Interviewer: Where the married couple could be having no sex and the single person could be having a normal sexual relationship?

Participant 9: Which is the case with me. The one case, the woman, they weren't having sex and they were married; and he's [the single client, different case] not married and having sex.

Examining some of these taken-for-granted-truths raises the question: are we really removed from our backgrounds and belief systems enough as developing psychotherapists to be non-judgmental enough to be able to assess an individual, leaving all of that out of the process?

5.3. Perceived differences between sensitive topics

Although sensitive topics tend to be grouped together, the experience of many of the participants was that there were varying emotional attachments to the various topics described as being sensitive. Many of the participants experienced more discomfort and attempted to avoid the topic of sexual health more than other topics such as suicide, alcohol, drug use and homicidality. Most participants felt comfortable with questions pertaining to alcohol and drug use and ensured that these sections of the interview were covered. This may allude yet again to the positioning of psychological enquiry within a medical framework. A participant felt that he was equally uncomfortable with the topic of suicidality as he was with sexual health. However, it is

interesting to note that despite his discomfort he will pursue the line of questioning around suicidality during each intake yet will avoid the topic of sexual health.

5.4. The taboo of discussing sex

Sexual myths result in ethical decision making about what is condoned and prohibited behaviour, which can be permitted and which deemed appropriate, and which behaviour may be condemned (Markovic, 2013). Taken-for-granted-truths enable the taboos of discussing sexual matters to remain so. Compounding this notion is the question of gender and who is permitted to discuss sexual health. Often it is a commonly held cultural rule, albeit unspoken, that women are not likely to discuss their own needs and desires even to their partners as women are not allowed to talk about sex (Tutani & Rankin, 2000). The taboo of open discussions about sexuality and sexual health seems to perpetuate a culture of silence around the topic which may permeate the therapy setting. It seems that the sexo-commercialisation of childhood, the easy access to pornography as well as general panic about sexual predators merge at a point in time that defines sexuality as either a sport, a purchase or as an act of violence, abuse or neglect resulting in sexual identity as well as the development of a sexual vocabulary to be fraught with negativity and many gaps (Orbach, 2009). This highlights the complex issues attached to any discussions around sexual health and wellbeing. According to Brandenburg (2009) there is a general feeling that addressing sexual issues is too intimate and this appears to be the experience of many of the participants.

Age seems to be closely linked to the taboos and rights related to talking about sexual behaviours and who is permitted to do so. An implicit meaning that appears linked to the taboo of discussing sex, sexuality and sexual health is illustrated in some comments by the participants alerting one to how taboo the subject is when even parents are unable to speak to their own children about sexual health. The interesting aspect mentioned here is that if parents are unable to speak to their children with confidence and comfort it creates the sense that this indeed is an unspoken topic. This may further complicate the trainee psychologists' ability to navigate their way through therapy when needing to address sexual matters. The implicit message is that it is an inappropriate line of questioning despite age, gender or cultural factors. The over-riding discourse is that sex is a taboo subject. The taboo of talking about sex would impact on the

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client's disclosure to the therapist and the client may in addition answer in ways that may be understood as being more socially appropriate. The taboo of discussing sex may be influenced by religious doctrine which may not permit the act or any sexual behaviour unless within strict parameters of marriage as an example. One participant succinctly summarises this section in his words:

Participant 10 (male): Yes, friends speak about cars, we'll speak about suicide, hospital but sex everyone suddenly turns their heads in surprise, so you know what society create. Yes it is society, once I speak about it people will judge me, I will be judged.

Wilkerson (2002, p. 13) labels this taboo as "cultural erotophobia" and explains that the taboo is not only with regards to open discussions of sex being deemed inappropriate, further that displays of sexual behaviours are taboo as well. This ideas and unspoken rules are an effective means of perpetuating the social hierarchies and maintaining and entrenching this taboo around the topic of sexual health.

Personal Reflections: *I was alerted to the fact that many participants were not in relationships and therefore this seemed to make the topic of sexual health more difficult when conducting the interviews. Perhaps it was due to the fact that some participants held strong beliefs that sex before marriage was not acceptable and fear of judgment from me. Or possibly a lack of vocabulary around the topic of sexual health due to limited sexual experience themselves. The fact that I am married seemed to imply that I would be more comfortable and more at liberty to discuss the topic of sexual health without judgment. All interviews felt comfortable and all participants eased into the discussion as the interview progressed. I am aware that had I perhaps been single it may have caused more discomfort for the male participants given the discussion regarding gender, the taboo associated with sexual health and taken-for-granted-truths.*

5.5. Invasion: Gender is in the room

Gender seemed to have the greatest effect on the trainee psychologists and it was this presence that was the most keenly felt during most interviews the trainee psychologists had had with clients. For some trainees it was an obvious obstruction in the room and for others it was felt on

a more subtle level and less overtly present, but present none the less. As stated by Perel (2007), women tend to become trapped by age-old ideas concerning female sexuality and what is deemed appropriate behaviour for a woman. Beliefs which hinge on men being the gender who seduces and pursues, and women as the passive and dependant gender were experienced by some of the participants during their interviews with clients. This discussion is closely linked to taken-for-granted-truths commonly held by society. (Section 4.3.2. p. 75). "She battles the age-old repressions of female sexuality that have trapped women in passivity and made us dependant on men to seduce us into sexuality" (Perel, 2007, p. 77). This quote illustrates the dominant gender discourse which has a profound impact on how a trainee psychologist manages the topic of sexual health where a male therapist may feel predatory and a female therapist may feel disempowered to engage with the topic adequately.

There are many ways in which dominant constructions of a woman's place within families and constructions of family life (Dulwich Centre Publications, 2001). A tendency to experience gender-roles and certain taken-for-granted-truths of males and females is apparent for many of the trainee psychologists. During the course of an interview the trainee psychologist is acutely aware of the gender discourses even though some of the participants struggled to articulate the implicit meanings. This may be due to a lack of insight into these discourses or a reluctance to verbalise these ideas as they are not socially appropriate responses, further strengthening the argument that sexual health is a complex topic to manage. Of interest is a comment made by one participant which again highlights the perceptions that society has of the differences in gender in relation to the topic of sex and that males are more sexual and therefore find it easier to engage with the topic of sexual health (section 4.3.2. p. 77). 'Crossing boundaries' with the opposite gender appears to be a concern for some of the participants and is only experienced in terms of gender differences. An interesting highlight indicating the strength of gender discourses was illustrated by a participant who had described feeling awkward during an interview with a male client when attempting to discuss sexual health. What is interesting is that the participant's sexual orientation of being gay was overshadowed by the dominant male/female gender discourse which predominates throughout society to such an extent that she was very aware of these gender discourses and rules of engagement. She was concerned that her client may

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perceive her as being too forward when discussing the topic of sexual health despite her sexual orientation (section 4.3.2. p. 77).

Personal Reflections: What emerges is that gender is felt profoundly by most of the participants, however, the participants struggled to articulate precisely why that is. There was much implied in the interviews about it being more comfortable to discuss the topic with a person of the same gender. My observation was that it seemed difficult to articulate where the discomfort comes from although each participant recognises the discomfort. Personally I feel that this highlights the salient feature of this research project that the implicit taken-for-granted-truths about gender are not deconstructed adequately in order to better understand social constructs and how they are maintained and impact the working relationship.

5.6. Age: a dominant discourse

The theme of age appears to have played a significant role for many of the participants in the discomfort experienced regarding the topic of sexual health (section 4.3.2. p. 76) Rheume (2008) appropriately stated that it is important to understand the lifespan view and to support people throughout their lives as having a right to express themselves sexually, and not limit sexual expression due to aging. Age affected the trainee psychologists in that it caused many to feel that they did not have a right to ask about sexual health. In many societies it is felt to be inappropriate to discuss sex with a person who is older than one as it is understood to show disrespect. In research carried out by Tutani & Rankin (2000) women from various cultures expressed this notion of having unsatisfying sexual relationships, intricately linked to the belief of age equating to passivity in relation to sexual functioning.

This illustrates a commonly held belief that older people do not engage in sexual activity and are indeed no longer sexual beings. This eludes to the belief that sex occurs within a limited time frame and therefore may be understood in biological and medical terms only. What this may indicate is a lack of understanding sexuality and the topic of sexual health has a far wider reach and range, and that individuals are the sum of a whole, sexuality being one of those parts. By not discussing sexuality with an older person implies that sexuality is not seen as an important facet of gerontological health and this perpetuates the discomfort of health care professionals being able to adequately engage in conversations around sexual matters (Rheume & Mitty, 2008).

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Although there were some concerns when questioning a client who was younger than the trainee psychologist, this age ratio was not felt as profoundly as when the client is older than the trainee psychologist. At times there appears to be discomfort when the client is the same age as the trainee. Interestingly a participant felt more at ease with a client who was older than the trainee due to the assumption that age had increased the client's knowledge base around the topic of sexual health. The implied meaning rests on the assumption that an older person has engaged in sexual activity and been able to learn about sexual matters.

5.7. Power imbalances

An important concept within the therapeutic setting is that of power ratios and that the power usually rests with the therapist due to her being the expert and professional. Adding to this imbalance is the fact that the client discloses personal information and the clinician discloses very little. This power ratio may be intensified when confronting sexual health enquiries as it is a topic perceived to be highly personal (McWilliams, 2004). The client enters therapy with a problem and in an attempt to become well or function better approaches the therapist for help. The location of psychology within a medical paradigm perpetuates the power ratio in favour of the therapist being viewed and expected to be the expert. This perspective may enhance the trainee psychologist's task related anxiety with the implicit understanding that she is expected to have the answers and know what to do. The reality is that at times the trainee psychologist feels out of her depth and this seems apparent specifically when attempting to manage the topic of sexual health. The process of seeking assistance from a psychologist sets up a power ratio in favour of the professional who is viewed as the expert and the client, often termed 'the patient' in a less powerful position. The medical paradigm reinforces this power ratio and it is important for the trainee psychologist to be conscious of how a power ratio may come to the fore within the therapy context. The role of 'expert' leads to guiding questions and avoiding others and the clinician has the power to dictate conversations. Hence an imperative to be mindful of power differentials in varying ways they may manifest as illustrated in the following discussion. The following quote emphasises a drive to rethink and question how power ratios are present in the therapeutic setting and the need for a collaborative stance: "Sensitivity to power differential embedded in the systems characterizes a therapeutic stance whereby therapy is aimed at client 'empowerment' through a collaborative therapeutic relationship" (Anderson, 2000).

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In order to better understand power balances and imbalances it is important to expand and explore ideas associated with social discourses which include gender and age discourses. There are commonly held truths regarding who holds the power in society and through a process of self reflection it may further assist the trainee psychologist to question power ratios and to be alerted to when and how these may arise in the therapeutic setting. Power imbalances are experienced due to cultural differences, and indeed within certain cultures, of who is allocated the power to engage in certain topics of discussion, is often clearly understood within that culture. In the words of McWilliams (2004) she describes an ideal relationship between client and clinician where the client feels grateful for the professional competence of the clinician but is not reduced.

5.8. Cultural diversity

Cultural diversity has been an area of growing research and discussion which seems to have resulted in better understanding of cultural differences. Multi-cultural training and development have attempted to draw the trainee psychologists' attention to a more mindful practice, particularly in a culturally diverse country such as South Africa. For the past twenty years the dominant discourse in South Africa has been one of embracing diversity and to encourage a culture of interest in other cultures (Swart, 2013). Perhaps it is this open discussion which has led to most of the participants feeling that culture is not an inhibiting factor when broaching the topic of sexual health. In some instances the cultural rules are strictly adhered to particularly regarding discussions about sexual health. It therefore seems that not only does one need to consider the implications of cross cultural encounters but also within a culture these rules may seriously impinge on this topic being raised.

Participant 5 (male): And cultural wise they were all black clients as well so it's something that is frowned upon nobody wants to talk about it so that terrain is: don't talk don't tell.

As indicated in the previous quote, perhaps it may be even more challenging when the trainee psychologist and client are from the same culture as there is an expectation that each individual will know the cultures implicit rules around the topic of sexual health making it more challenging. According to Rust, Raskin & Hill (2013) trainees need to be particularly aware of not imposing their own beliefs and values on a client. This may be experienced if the trainee has a negative perspective of a particular cultural group fueled by taken-for-granted-truths. This may

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pose a profound obstacle for the trainee psychologist and have negative consequences on the therapeutic process. However as the findings show (section 4.3.5. p. 80), this study did not elicit insurmountable obstacles concerning culture as a barrier to the management of the topic of sexual health. Most participants felt adequately aware and competent engaging in cross-cultural discussions. It was noted that the trainee participants would benefit from further discussions to improve their skills in understanding other cultures.

5.9. The use of language and the power of words

"We have so many words we use to talk to ourselves about human beings that our own speaking to ourselves can easily bewitch us", a quote by Tom Anderson which is a loaded and beautiful statement describing the power of words and of language (Malinen, 2012, p. 56). Language can impact the ability to have a discussion about sexual health. One way in which it may impact the process is due to actual differences in language where the client is not fluent in the language being used by the trainee psychologist. A language difference may be experienced when there are not adequate, sufficient or appropriate translations from one language to another and this may impinge on the trainee psychologists' ability to question around the topic of sexual health. Subtle nuances that cannot be conveyed from one language to another is a well documented obstacle the world over. Such nuanced understanding comes with a solid, deep understanding of a language and not only from knowing the rules and grammar of the language. Nuanced understandings are understood by the subtle use of the words themselves and how they relate to certain contexts.

It is vital for the trainee psychologist to be aware of how values and morals are implicitly conveyed via the use of language (Burns et al. 2013). The choice and use of certain words may hold different meanings from one person to another and therefore it is important to check that the meaning of a word used by a client is understood or to clarify the choice of words used by the trainee psychologist.

Without a good vocabulary it can be challenging to find words to use that do not complicate questions around the topic. What emerged in this study is the experience of being clumsy in the choice and use of certain words and a lack of knowing which words to use for who and at what time (section 4.3.6. p. 82). Examples of words used were: activity, pleasurable activities and intimacy, all of which can have various connotations depending on the context the word is used

in. Some participants aimed at approaching the topic in a "soft manner" yet were unable to articulate what this meant in practice. Intricately linked to culture and taken-for-granted-truths is the concept of language and highlights the imperative of assuming a not-knowing stance and a collaborative approach to assist in the navigation of such a complex subject. Furthermore it raises a pertinent debate regarding the western framework of psychology and whether it is a suitable fit in a multi-cultural setting, further propelling the need for a postmodern paradigm.

5.10. Religious beliefs: taken-for-granted truth

The impact of religion on enquiries regarding sexual health are deeply connected to ideas of judgment (Smith, 1999). One participant experienced conflict regarding religious expectations, as he felt anxiety in attempting to reconcile his own beliefs with being required to ask about sexual health comments presented in the findings section relating to religious beliefs, reveal how commonly held ideas of certain religious groups impacted the trainee psychologist's ability to negotiate the topic of sexual health (section 4.3.7. p. 84). Assumptions seemed to come to the fore regarding religious beliefs and perpetuate a cycle not only of silence but the ideas associated to particular religions. Religious beliefs inhibited the trainee psychologist's ability to raise the topic of sexual health as well as impacted her view of the client in relation to sexual health.

5.11. Understanding the relevance of sexual health

" I have been struck by the lack of discussions on sexual issues in psychotherapy training and practice..." (Markovic, 2013, p. 313). It was apparent that most of the participants did not have a grounded understanding regarding the enquiry into sexual health (section 4.1.2. p. 59). This lack of understanding the relevance impacts the feelings of anxiety, discomfort and clumsiness of handling this topic. One participant felt she needed to have a grounded knowledge in what the aim of her questions were for. She could understand the legal requirements of asking about previous arrests, as an example. She understood the necessity of gauging the risk of suicidality. However regarding sexual health information she felt uncertain of the pertinence of the questions as it was not grounded in relevance and a theoretical connection to anything to justify her questions (section 4.4.3. p. 88). Furthermore many cases at the Applied Centre for Psychology are assessment cases and a participant raised an important issue pertaining to assessment cases which indicates the lack of thorough knowledge regarding the relevance of sexual health

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information. This participant was unsure whether it was a relevant enquiry and if it was she was uncertain if it was relevant for the parents of the index client or for the index client.

It may be useful to understand the relevance of sexual health by holding two world views in mind concurrently. The understanding of sexual health does not need to be viewed from mutually exclusive positions of: either looking for symptoms and pathology, or at the meanings attached to sexual health. It is possible to draw on the vast knowledge base of dysfunction, symptoms and pathology, and marry this information with a more systemic understanding which can expand and tease out an individual's loyalties, beliefs and traditions attached to their ideas of sexual health (Markovic, 2013). The topic of sexual health is so dynamic that it cannot be looked at for the absence of symptoms only or an understanding defined only by symptoms. An absence of illness is guided by the semi-structured interview used in the initial interview with a client. Viewing sexual health from a biological perspective limits the ideas that sexual health can be determined to be distressing even in the absence of pathology. For example a client may be unable to engage in sexual activity due to a biological problem. However a client may refuse to engage in sexual activity due to contextual factors associated with taboos regarding sexual activity. Sexuality is an important means of experiencing pleasure as well as interpersonal connection and these aspects are closely linked to feelings of self-efficacy and the acceptance of one's self and body (Wilkerson, 2002). The nuanced understanding relating to the relevance of sexual health information is vast and therefore calls for exploration into the subject and not avoidance thereof.

5.12. Self - doubt

The trainee psychologist finds herself in a challenging context as she is very closely monitored not only by lecturers but also by supervisors as well as her peers. Another 'critic' is the internal critic of the self and these may all influence her feelings of inadequacy and self- doubt. The challenges the trainee psychologist faces are many and added to this the attempt to manage the content of sexual health within the first interview with a client. The social taboos and discomfort attached to the topic of sexual health may further add to her own self-doubt. The training program requires that the trainee psychologist records her therapy sessions and this has been reported to further raise feelings of self-doubt. Self -doubt relates to the limited conceptual maps

which the trainee psychologists have when dealing with sensitive subjects such as sexual health (section 4.1.4. p. 63 & section 4.2.1. p. 70). Emotional maturity as a function of a developing psychotherapist assists in clinical skills development, judgment and insight as described by some of the participants who through personal experience felt better equipped to engage in the topic of sexual health.

5.13. A question of ethics in relation to sexual health information

Beliefs and value judgments connected to sexual myths result in a clinician making judgments according to what acts are deemed acceptable and those that are not (Markovic, 2013). It therefore is an imperative to examine sexual myths and value judgments. To view the encounter between clinician and client is to provide a framework in which the meaningful and appropriate conversation of morality may occur in a way that it allows freedom and openness while also being mindful of limitations (Burns et al. 2013). The act of therapy places weighty, ethical considerations on the trainee psychologist. The psychology profession guides the trainee psychologist through complex ethical standards which are crucial to the service provided. These ethical complexities may be overwhelming and it can be hypothesised that enquiries regarding sexual health may further complicate the intake interview process and the gathering of sexual health information. Buehler (2014) draws attention to the beliefs and training of psychologists as having strict prohibition about sexual behaviour, intimacy or over-familiarity with a client and that this has added to the fear and hesitation of speaking about sexual matters. It is this fear and rigidity around patient - client relations that may be one of the causes of silence and the lack of exploration about how sex can be discussed safely within therapy (Buehler, 2014).

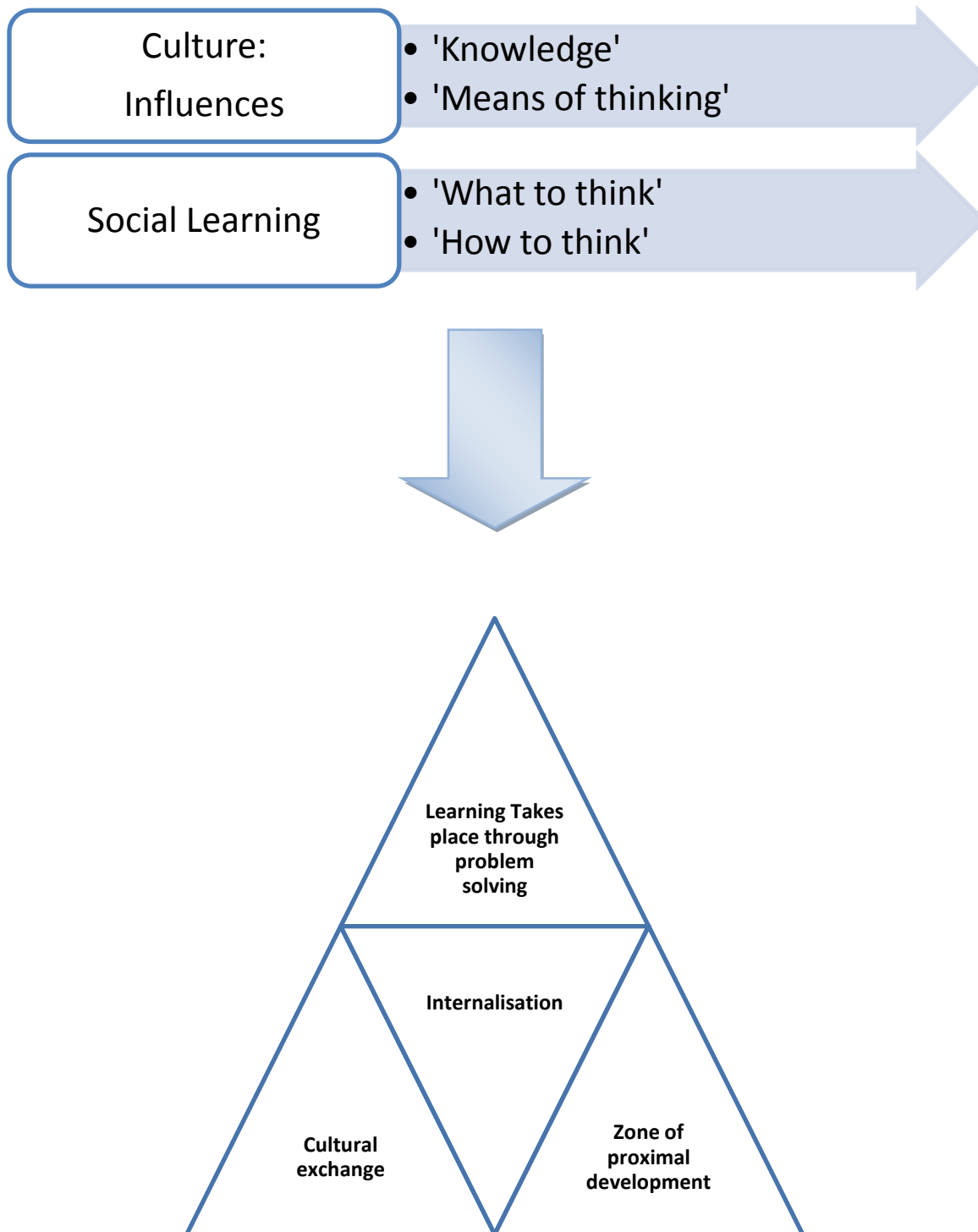
Adding to this dilemma is the constructed idea that as a professional there is specialist knowledge and that the professional can fix, guide and help (Swart, 2013). The topic of sexual health requires not only knowledge in the field of sexual health but also a sound understanding of ethics. It is difficult for the trainee psychologist to remain neutral and manage these factors. Therapy is a 'political' act in that all problems or challenges that a client may experience may be subject to exist within the scope of a socio-political landscape where power relations are felt (Russell & Carey, 2004). This stance positions the therapist and aids at being a reminder of the ethical responsibility towards clients. As explored in this study there are a number of factors

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which further complicate the ability to manage the topic of sexual health information. Many participants spoke of boundaries and feeling concerned about crossing the boundaries in relation to age, gender, culture or religion regarding the topic of sexual health. It is important that training programs ensure that trainee psychologists are not only adequately trained but have developed a sound understanding of ethical practice which includes being free from any apparent psychological and struggles with relating to others (Rust et al. 2013). Added to this is the growing notion that attention to ethics and to social justice calls for practices which encompass social justice and are inclusive of a practice that incorporates broader society and political contexts (Madigan, 2010). This stance demonstrates an acknowledgement of how political contexts and social discourse shape identity and the meaning attached to certain subjects. According to an article written by Burns et al. (2012) the premise is put forward that psychotherapy can no longer be viewed as being 'value-free' and contend it cannot even be understood to be morally neutral. Therefore the imperative is for all clinicians to acknowledge that psychology is deeply complex and filled with moral assumptions and the positioning of the clinician needs to be observed and acknowledged (Burns et al. 2013). Thus the practice of psychology is a moral encounter between clinician and client and can have a profound impact on the client, specifically regarding sexual health.

Participant 8 (female): Yes being something that you're not or trying to play that role, you only get stuck. Just to be yourself in everything that you do, use yourself as the tool because they can tell and as I grew I loved that with the structure. But it has to come from a place that you're genuinely concerned... you genuinely want to know about this person and you're actually showing them that they are important ... the only way to do it is to be yourself.

Diagram 4: Social Constructivism



5.14. Collaborative strategies

5.14.1. Assuming a 'not knowing stance'

Out of the modern and structural approach developed an understanding of psychology forged on the premise of "natural scientific models" (Burns et al. 2013). This positioning of the clinician as that of being the expert, and morally neutral, who interacts with a client in need of being understood through the combination of scientific theory and moral neutrality (Burns et al. 2013). The result of this stance is that it places the clinician, in this case the trainee psychologist, in the 'expert' position who is required to know how to fix, correct and guide the client. The topic of sexual health is encumbered with a variety of factors which places a vast expectation on the trainee psychologist to be an 'expert' when managing this topic. This may possibly result in a disconnect between getting to know the client within her context and reducing the relationship that of 'expert-helper' with the expectation that answers or a diagnosis will be provided. This stance ignores the possibility of the client being the expert in her own life. It is possible to develop a stance where both clinician and client are the experts, each being able to teach and assist the other (Markovic, 2013). Through adopting a not-knowing stance encourages the client to engage in her own constructions and meaning making and in so doing assists at ensuring a decentering of power often experienced in the therapy context (Swart, 2013). Reinforcing this idea is what Morgan (2002, p. 86) refers to as the "consultative-stance".

This may result in alleviating the expectation on the trainee psychologist to have all the knowledge, and assist in creating a collaborative space to question meanings attached to the topic of sexual health. Assuming a not-knowing stance particularly regarding sexual health may lessen the client feeling judged and allow a space where both clinician and client engage in a process of deconstructing and reconstructing the ideas associated with sexual health. According to Markovic (2013) the goal of therapy would therefore focus on co-creating a context between clinician and client which encourages the client to explore alternate possibilities and in so doing to move away from pathologising their struggles. When dealing with the topic of sexual health it may be beneficial to present the topic in an informative way, as practiced by sexologists, inquiring around preferences and experiences and encouraging a collaborative relationship (Markovic, 2013). The crux of the clinician's standpoint is the response being neutral and using

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a not knowing stance by following the client's language and assuming a non-directive approach (Markovic, 2013).

Personal Reflections: Assuming a not-knowing stance was helpful during the course of the study as I have my own preconceived ideas relating to sexual health and had to be mindful of any assumptions I may have had during the course of the interviews. Another area I experienced a not-knowing stance as being highly beneficial was during the collaborative process with my research supervisor who was willing to have his own ideas challenged and to explore this subject matter, as well as the presentation of this study. For me this reinforced the power of collaborations and assuming a not-knowing stance.

5.14.2. Developing reflexive skills and broadening knowledge base

At a postgraduate level of training the trainee psychologist has built a solid theoretical base and has been required to show insight and personal development. An ongoing area of education in the field of psychology is to encourage constant growth and personal exploration. This concerns taking a position of how looking at how one's life is influenced by culture, history, sexuality and other broad relations of power (Russell & Carey, 2004). This is intricately linked to examining taken-for-granted-truths.

Participant 8 (female): Being genuine and also, not practice but forcing myself to overcome that challenge, not looking at it in fear but force myself to delve into it, research about it, ask people about it, finding ways to doing it, saying it. Finding out the 'why' part for yourself.

The importance of a reflexive stance is that it requires the trainee psychologist to be highly sensitive to her own beliefs and experiences and how these may impact therapy. Most of the focus of this research has been on building a knowledge base on which to draw on when dealing with the topic of sexual health. Conversely the trainee psychologist must be mindful that clients may struggle to talk about sexual health and that a self-reflexive stance awakens the clinician to various ways in which her presence may be felt during therapy. "The concept of relational reflexivity extends the self-reflexive process onto the therapeutic relationship and allows for an explicit exploration of it by involving clients in reflecting on these processes" (Markovic, 2013).

5.14.3 The skill of questioning

According to Macdowall et al. (2010) it is vital to practice phrasing questions and to practice through role- plays so that a trainee psychologist has the opportunity to develop a vocabulary and phrases to use when discussing sexual health. This highlights the importance of being able to find appropriate words to use and neutral phrases which are comprehensible and acceptable within the therapeutic setting (Macdowall et al. 2010). Asking questions is a useful method in this attempt to explore multi-relational aspects and experiences of an individual specifically regarding a complex topic such as sexual health. The postmodern view posits that identity is not fixed and it is therefore through the questioning process that enables an individual to explore relations with sexual health topics (Russell & Carey, 2004). A trainee psychologist has to develop insight into how she is a product of her context and the way in which she attaches meaning to certain subjects and beliefs. In 'knowing' herself she may be more at ease with dealing with ambiguities and differences in the therapy setting. This understanding and her own ethics, guide the way in which questions are asked and which questions will be asked during therapy and which will be ignored. Broadening the understanding that therapy is a moral encounter and in being transparent and having the confidence to "place one's moral cards on the table" is an attempt at acknowledging the importance of the clinician and her values, ethics and morals (Burns et al. 2013, p. 10).

The training of a psychologist cannot be limited to the trainee psychologist merely reflecting and using skills which have been taught (Rust et al. 2013). The skill of questioning then cannot be taught and regurgitated. The meanings and understandings attached to the subject matter need to be understood in order for questions to be relevant. A salient feature of the use of effective therapeutic questions are questions which aim at and indeed achieve the conversation to be expanded and explored and not to be shut down (Markovic, 2013).

5.15. Collaboration with peers and supervisors

A collaborative stance reduces power differentials and opens a space for the trainee psychologist to extend reflexive skills and to develop the confidence of taking a not-knowing stance. Through conversations with peers and supervisors this can be a highly useful addition to the teaching program and reduce the feeling of being so 'watched'. Collaboration between peers and

supervisors may indeed allow the trainee psychologist to practice the skill of using collaborative strategies with clients particularly during the segment of enquiries regarding sexual health information. Supervisors play a significant role in containing the trainee psychologists' anxiety and encouraging development and insight into blind spots. Collaboration seems to be imperative regarding sexual health due to the complex nature of the subject and by avoiding it during training or supervision may perpetuate the taboo of discussions around sexuality.

5.16. An epistemological question

"Perpetually seeking to legitimize itself alongside the medical sciences, psychology gravitated toward a reductive discourse that emphasised naturalistic and positivist epistemologies" (Burns et al. 2013, pg 4). Epistemology rests on suppositions inherent to analysis of observations, explanation and ideas and how these are related (Madigan, 2010). The field of psychology is predominantly positioned within a medical and allied health framework. This position guides methods of inquiries about human behaviours in a way that requires observations and explanations, which in turn lead to symptomology and diagnosis. The therapeutic frame thus holds a moral imperative of how an individual is understood and by default then, what constitutes the norm or how symptoms are understood (Burns et al. 2013). In understanding sexual health, as has emerged in this study, the topic is more easily managed by the trainee psychologist at times when structure and a search for symptoms legitimise this course of scrutiny. What is lacking is the understanding of sexual health in a more nuanced way and how intricately interwoven it is with human experiences and meanings. A postmodern paradigm views the person within a context in relation to the world, and how that has influenced the understanding of sexual health. The trainee psychologist comes to the initial interview with a schedule to guide the gathering of history from a client, based on this epistemological understanding. However, ideologies shape epistemological decisions and often this is not investigated by the trainee psychologist (Madigan, 2010). Ideologies highlight the connections between socio-political discourse and social ideas and this was a powerful theme to emerge in this study. The root of this study raised the issues of how a trainee psychologist deals with obstacles when inquiring about sexual health. The obstacles appeared to be particularly revealing of underlying discourse and beliefs. Therefore this brings awareness to the importance of personal development in understanding discomfort regarding the topic of sexual health.

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A salient feature to emerge during the course of this study is that the uniqueness of each participant and how unique contexts of culture, age and gender influence the manner in which the topic of sexual health is managed. Although the training meets all requirements to educate and maintain a certain level of education required to become a qualified psychologist, there is anecdotal evidence pointing to the onus resting with the individual to develop reflexive skills and broader understanding of how client and therapist are socially constructed beings. The use of a structured interview assists the trainee psychologist initially however, it maintains the position of the psychological interview being further galvanised within a medical framework. Medical authority appears to serve as a means to justify and reinforce cultural norms. By drawing on a postmodern paradigm may assist the trainee psychologist to move from a structured, medical view of the person and to develop a more dynamic and flexible form of dynamic interviewing anchored in personal reflection and growth of the trainee. It requires a review of current ideologies. It requires a move away from viewing sexual health as a concept on its own and towards the view of sexual health in relation to the individual and her world, both the client and specifically the trainee psychologist.

Participant 7 (female): Yes now I understand why it has to be the whole package.

Interviewer: Yes because it builds a picture of a whole person.

Participant 7 : Yes and sexual history provides direct information about needs going un- met, trying to conform to social norms, now I can see that from a different perspective.

CHAPTER SIX

6.1. Synopsis of results

Through the use of the phenomenological approach and allowing the experiences of the trainee psychologists within this study to be reviewed, this chapter consolidates the emerging themes. This research has revealed insights and meanings attached to the topic of sexual health and how the trainee psychologist, within her context, has been constructed and how she attaches meaning to sexual health information.

Main Question 1

What obstacles were faced by trainee psychologists when gathering a history from a new client with a specific focus on sexual health and sexual history?

Sub question

Was there a differentiation between process and content?

Sub question

How were obstacles directly related to the trainee psychologists personal contexts?

Main Question 2

Looking at contextual factors and how these impact the trainee psychologist

Sub question

How did the personal meaning of the obstacles affect the working alliance and therapy process?

Sub question

What strategies were used to overcome the obstacles and what understanding did the trainee psychologists have of the relevance of sexual health information?

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A careful review of the literature explored, served to draw attention to the focus points of this research as well as stimulating and generating further meaning to the topic.

6.2. Obstacles faced by the trainee psychologists when gathering sexual health information during the intake interview

The primary obstacle faced by the trainee psychologists was related to subjective discomfort and personal meanings attached to the topic of sexual health. A limited language bank to draw on inhibited the trainee psychologists feelings of competency to manage the topic. This was compounded by limited experience to draw on in terms of understanding the relevance of sexual health information. The main question led to the subsequent questions as follows:

6.2.1 Obstacles in relation to the self: Personal discomfort of the trainee psychologist

Most of the participants in this study recognised that the discomfort they experienced at the time of questioning, or attempting to question about sexual history and sexual health, was a subjective experience. The topic of sexual health is a complex one that is deeply entwined with many contextual factors. One participant recognised that her discomfort was due to her lack of sexual experience and therefore felt unable to engage appropriately with her client on the topic. Another participant described herself as being a very private person and for that reason felt it was not appropriate for her to ask a client such personal questions. An overwhelming pattern that emerged was that through the lack of understanding of how to link sexual health information to other facets of the person, most trainee psychologists avoided the topic, deeming it unimportant. The majority found that the basis for asking about sexual health or sexual functioning was for the purpose of teasing out symptoms and possible links to pathologies. Using a medical and structured framework eased their discomfort as a justification for asking such problematic questions.

The lack of knowledge coupled with feelings of discomfort around the topic resulted in most of the trainee psychologists attending very little to the topic during the initial interview. Although there is a large amount of information to gather during the intake interview, sexual health was avoided more often than not despite other sensitive topics such as suicidality regularly being covered. The social taboos and contextual factors particularly gender, age and culture which seemed to be dictated by unspoken rules and entrenched beliefs magnified discomfort. Some of

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these contextual factors and unspoken rules imply that to talk about sex is an invasion of privacy or as one participant described, as being invasive. An intake interview is highly personal act as a client is sharing information about themselves they may not have shared previously. Therefore the therapy process is highly personal and the integrity of handling such information is paramount, regardless of the topic. However it was only during the segment of questioning around sexual health that some participants felt asking those questions was what was considered to be 'crossing boundaries'. Gathering other personal information did not cause the discomfort that sexual health did and this study sought to explore the factors that influence this subjective discomfort.

What emerged during the research interviews is that the topic of sexual health is found to be taboo within the home and society at large. There is limited focus on sexual health during the training program and it may be worth noting that this may perpetuate the cycle of restraining sexual health language and restrict developing a foundation of sexual health knowledge. During the process of the research interviews some of the participants commented that the interview had prompted insight into their own world views of sex and sexuality and some of the taken-for-granted- truths about sexual health. The interview process had facilitated an awareness to further some of the participants own exploration around discomfort and knowledge concerning the topic of sexual health.

6.2.2. Obstacles in relation to limited understanding of the topic: sexual health

Many of the trainee psychologists in this study had little experience in engaging in this part of the intake interview. The research interviews revealed a differentiation between general performance anxiety related to the task of the initial interview and the ability to converse and manage the topic of sexual health. The general consensus was that despite the initial interview with a new client being an anxiety provoking experience, this anxiety is managed most of the time and does not impeded the process. However the ability to discuss sexual health raised anxiety and discomfort which was understood to be a subjective experience.

The medical paradigm and linking symptoms and pathology was the most common way in which the trainee psychologists understood the need to use questions concerning sexual health. The main focus for the inquiry during the intake interview was to ascertain whether the client had

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depression, as an example one participant used. This was the frame which justified asking such personal questions and once a symptom was either present or not, the topic of sexual health was not given much more consideration. One participant mentioned that perhaps information about sexual functioning may indicate how the client relates to others though struggled to articulate this. However the majority did not see the links, as mentioned in the literature review, to the many other aspects of the person. When inquiring about sexual health it was often viewed as a separate entity and not viewed as a part of the whole person. This limited view perpetuates the taboo and silence around sexual health. When encountering a client it is with the view of the person as a whole and sexuality as part of that whole yet throughout this study the trainee psychologists had a limited understanding of this integrated whole. There lacked a depth of linking sexuality and sexual health to subjects such as relationships to others and the self, self-esteem, body image to name a few. Furthermore there was a lack in understanding why these questions may be useful in developing a more complete picture of the person and how the person relates to their context and indeed that by ignoring the topic perpetuates a cycle of silence and taboo. Sexual health is a vast topic and the meanings attached to the topic are highly complex. Within an intake interview it may be avoided for this reason and this study revealed a debate regarding the timing of such questions and when they may be appropriate. However most participants stated they would avoid the topic if they could, even in subsequent therapy sessions. This highlights the lack of depth in understanding and a lack of confidence in managing the topic. Most participants felt they had an inadequate vocabulary and limited knowledge base to draw on and that this area required further exploration and development.

6.2.2 Obstacles in relation to the working alliance

Of particular interest is that the working alliance was not affected by those trainee psychologists who were able to raise the topic of sexual health despite subjective discomfort. Most participants recognised that it was their own discomfort that inhibited the process and not any cues from their clients. The trainee psychologists expressed that it was due to the approach they used and the way in which they presented the topic of sexual health that resulted in any discomfort perceived in the client. This reinforces the emerging themes within this study that the subjective experiences of the trainee psychologist are the key points in understanding this topic and its broader implications. It illustrates how the trainee psychologist is socially constructed and it is

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through this construction that she has made meaning of sexual health and how she manages the topic.

6.2.3. Strategies used to overcome the obstacles

The strategy employed most often was that of avoidance. Most participants commented that they would choose to avoid the topic unless it was directly related to the referral question. One participant described how she would leave the topic until the end of the session almost in the hope that she could avoid it. Those participants who were able to ask any questions about sexual health did so by asking one question, usually linking it to a medical understanding and then rushed on to the next part of the interview schedule. Very little time was spent on the topic and most felt relieved when it could be ticked off on the schedule.

6.2.4. The need to expose taken-for-granted-truths

Through a reflexive process most of the participants were alerted to their own prejudices and meanings that they had attached to the topic of sexual health. One participant had made it her goal to understand her discomfort and to explore the topic of sexuality as she had become aware of her limited understanding during the course of the role-plays. The participants who were more at ease with managing the topic of sexual health had experience in sexual matters either through relationships or had been exposed to the topic through a working environment with a focus on sexual health. This highlights the importance of exposure to the vocabulary required regarding the topic and a deeper understanding of human sexuality and sexual health.

6.2.5. Multi-factor implications: Spotlight on gender

Sexual health is complex due to the fact that it is affected by gender, age, culture, religion and political discourses. Each factor brings with it a plethora of taken-for-granted-truths and unspoken rules. However the most overtly experienced factor to emerge in this study was that of gender and indicates the strength of gender discourses even in this modern era. A pertinent comment made by one participant was that despite her homosexual orientation she was highly aware of the male/female discourse and unspoken rules which govern who can say what and to whom. She expressed her disbelief that although she is gay, she was concerned about how her male client would perceive her questions about sex, fearing the innuendo that she was too forward. Another participant struggled to articulate her shock at her own reaction towards a

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male client who was paralysed. She was sad for him due to the fact that he would not be able to have sex and her shock was at the realisation that she equates males and sex so strongly. What disturbed her further was that she felt it may be easier for a woman to be in that position of being paralysed as it is generally accepted, a taken-for-granted-truth that women are less sexually oriented than men. This highlights the gender discourse discussed by Orbach (2009) of associating masculinity with sexuality and expectations such as that females are required to be demure and often not equated as sexual beings.

6.2.6. Paradox of modern era and a censorship of sexual discussions

Some participants recognised the influence of media, both written, visual and social, of how these ideas of sex, relationships and gender stereotypes are perpetuated daily. The exposure of modern humankind to sex and sexuality is difficult to ignore and the taken-for-granted-truths are regurgitated in many forms. However, trainee psychologists, despite being highly trained at an academic level, have engaged very little in questioning how these discourses are kept alive even within the context of therapy. Almost all people are involved in a relationship and engage in sex at some time in their lives. Most people may have struggles with sexual health during the course of their lifetime. Sexuality is an integral part of the makeup of a human being. Despite the above stated comments discussions about sex, sexuality and sexual health are limited within a training setting and amongst peers. It seems paradoxical that exposure to imagery and the availability of sex and sexuality has not prompted more open discussions about the topic. Yet it still is a taboo subject dominated by gender discourses and affected by cultural norms and taken-for-granted-truths about age. Sexuality for all its various uses in advertising and entertainment never the less remains a feared facet of the body, particularly when bodies and behaviours are perceived to fall outside an extremely narrow and rigid norm (Wilkerson, 2002). It begs the question of whether avoiding the topic of sexual health in the intake interview perpetuates the idea that sexuality and sexual health is censored even within the therapy context.

In Closing: Who has the right to say and ask what?

Bridging the gap between theoretical training and the practical component of a training program is of central importance for the trainee psychologist. The trainee moves from a theoretical field to an applied field within a few months where it is expected that she will have mastered core competencies and be sufficiently trained to engage in the therapy process with a client. Establishing a good rapport and a working alliance with a client is of great importance and it requires skill in navigating through difficult territory when obtaining information from a range of challenging topics. During the course of this study project it appears that there are no clearly defined rules regarding which factors affect the ability to handle sensitive topics such as sexual health. The diverse nature of people, age, culture and belief systems does not elicit a clearly structured manual on how to approach the topic of sexual health. However a focus on the personal context and personal insight of the trainee psychologist appeared to be the most valuable feature to arise from this study. Such an outcome has close links to the postmodern view and a post structural paradigm of understanding the individual in relation to her context.

Perhaps the important themes that have emerged are indicative of the need to challenge the taken-for-granted-truths which perpetuate through all levels of society and reinforced through the media. It appears that the crux of this study is not in building a repertoire of questions to be asked within the therapy context that can be applied to each client. Nor does it seem apparent that a deep understanding of a topic as complex as sexual health is something that can be taught within a training program. What it seems to highlight is the profound need for the trainee psychologist to understand herself within her context and to know where she positions herself in relation to various topics. It is only with a contextual understanding and relationships with the outside world and dominant discourses that the individual trainee may find a comfortable place to work with a client, regardless of the topic and despite ambiguities. Any contact with a client within a therapy context requires a deep humility and compassion regardless of the subject of conversation. A client is in a vulnerable position regardless of whether sexual health is being discussed or not. The practice of reflexivity is paramount to an ethical approach to therapy. Although this study elicited the fact that there appears to be a lack of understanding the relevance of sexual health information, it does not seem external education per say is enough to allow the

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trainee to handle it with competence. Understanding a topic as broad and complex requires a more nuanced understanding of sexual health and the onus thus seems to rest with the trainee psychologist to develop personal, contextual understanding of the self and guidance in this area from the training program, facilitated by lecturers, supervisors and peers.

CHAPTER SEVEN

7. Implications and Limitations

Considering the emerging insights of this study I would like to make some additions to current understandings of how the topic of sexual health is managed by psychology professionals, specifically trainee psychologists.

7.1. Future directions: preliminary reflections on future development

The salient feature of a postmodern view is that the world is in constant flux which brings about ever changing ideas and understandings. Although illustrated in this study the topic of sexual health is still fraught with inhibiting beliefs and the dictates of age-old ideas relating to sexuality. Research aims to enlighten and stimulate the growth of new meanings and understandings. The precise mechanisms of how trainee psychologists manage the topic of sexual health are not fully understood which strengthens the premise of this study which is to embrace a postmodern view espoused in ideas such as challenging taken-for-granted views and assuming a not-knowing stance. Future development should constantly be seeking to move with the flow of new ideas and to continually re-examine taken-for-granted truths and challenge meanings that have become outdated and or are no longer useful. Trainee psychologists are positioned ideally within a training program supported by their peers and supervisors for challenging ideas and generating new ones in an attempt to better serve their clients and expand personal insight.

7.1.1. Future directions for professional practice

Drawing on postmodern ideas focuses the attention on viewing the client in relation to the context and how the individual has developed within this context. Therefore I encourage professionals to engage in these ideas and to explore what it means to take on a not-knowing stance. As professionals it can be a daunting prospect to feel pressured to have the answers and know how to manage difficult subjects and ambiguous feelings within a therapeutic setting. Using a collaborative stance honours the client's understanding of their own problem and facilitates conversations which promote personal development of both clinician and client. Specifically when dealing with the complexity of sexual health the use of a not-knowing stance and collaborative strategies may be highly useful and beneficial.

7.1.2. Future directions for training

Another salient feature is assisting the coordinators of a Psychology Masters program to structure such a program to optimally prepare for the therapy context. It is hoped that a study such as this one may assist trainers to deliver professional and sufficient training for the trainee psychologist to become a successful and competent interviewer. Trainees experiencing discomfort and unarticulated conflict in values are encouraged to take special efforts in exposing themselves to accurate information, interpersonal interactions and social contexts relevant to the values of the clients they may be dealing with (Farnsworth & Callahan, 2013). Including collaborative strategies within a training program might serve to ease some pressure for the trainee psychologists of feeling the need to perform and meet the expectations of being a professional and knowing how to manage complex issues. Developing the person and creating a platform to explore and practice having conversations about sexual health is beneficial.

Some questions to ask as a trainee: Whose view is this?, How do I know this?, What am I putting emphasis on?, What ideas am I privileging?, What are my limits?, What is my place of my judgments in this work? (Markovic, 2013).

7.1.3. Future directions for research

To further explore dominant discourses and how prevalent they are within the trainee psychologist. This should be an ongoing process and one under constant review.

7.2. Limitations of the study

During the course of developing the semi-structured interview to be used for the study it had been anticipated that the working alliance would be a prevalent issue. However the working alliance was overshadowed by other aspects of the discussions/experiences by the trainee psychologists and the study evolved in a way not initially anticipated. The postmodern conceptualisation grew out of this and indeed seems to have added depth not considered during the planning phase. There are 12 participants in this study, however due to technical problems with recording equipment I was unable to use participant 12's interview. Participant 11 was written down however during the interview, the recording was damaged.

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7.2.1. Generalisability

It would be beneficial for this study to be repeated within other training programs throughout South Africa in order to see if these results are transferable to other populations. It would be valuable to explore whether the obstacles that arose in this study are commonly experienced within other therapeutic settings as well as transferable to the general population.

7.2.2. Availability of participants

Due to the scarcity of the participants and time constraints for the Masters students, I approached participants from the previous masters year, who are currently in their internship. There were 3 male participants, only due to limited male students within the psychology program.

7.2.3. Personal reflections

"Reflexivity requires awareness of the researcher's contribution to the construction of meaning throughout the research process, and an acknowledgement of the impossibility of remaining outside of one's subject matter while conducting research" (Terreblance et al. 2006). The topic of sexual health has been of particular interest which has been magnified since having three of my own children. I was raised in a home where sex, drug use, alcohol use and many other complex subjects were often dinner time conversation. Due to this I have read widely about sexuality and gender issues. As my own children have grown I have been faced with questions about sexual health from them which have required honest answers and personal reflections. My assumption was that at a post graduate level my peers would feel as confident and comfortable to discuss the topic as I was. However I soon became aware that I was one of the few to have developed a vocabulary and knowledge base about human sexuality. It was during the course of my Masters year and role-plays with my peers that stimulated some of the questions about taken-for-granted-truths and sociopolitical discourses surrounding sexual health. HIV/Aids has illustrated how some of these myths and ideas about gender, age and culture perpetuate these discourses and inhibit open discussions about sexuality. During my Masters year a series of workshops on HIV/Aids had a profound impact on my peers and myself and generated enlightening discussions about sexuality in various contexts.

I am aware that during the research interviews I prompted more than I had intended to as some of the participants initially struggled with the topic of sexual health and due to limited

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experience in discussing the topic were at times unable to articulate what they needed to. However I was aware how in each interview, after twenty minutes, each participant had relaxed and eased into the conversation which in itself strengthens the discussion about subjective discomfort. What I found most interesting was that during the course of this write up I often found myself writing Male in capitals and female in small letters which alerted me once again to the subtleties of gender discourses. Of course this requires ongoing reflecting on my part. I felt it was important to choose to use her instead of the commonly used her/him in this write up due to my own feminist leanings and engagement with narrative discourses. I have used him when commenting directly about one of the male participants in this study.

7.2.4. Possible contributions of the study

It is my hope that this study serves to stimulate the thinking and the challenging of taken-for-granted-truths. To live and practice psychology in a manner which honours others and continually ignites passion and curiosity is the aim of this research. I feel the strengths of this study may make some contributions to the field of psychology aiming at expanding views to include a holistic view of the person, including sexual health.

7.3.1. Addition to psychological knowledge regarding sexual health information

This research explored underlying themes which may inhibit or promote the ease or discomfort a trainee psychologist manages the topic of sexual health during the intake interview with a new client.

7.3.2. Encouraging a reflexive stance and personal growth

This study may provide stimulating reading to encourage trainee psychologists and professionals to assume a reflexive stance particularly regarding such a complex topic as sexual health. Furthermore to promote constant re-evaluating and challenging the taken-for-granted-truths and to practice taking a 'not-knowing stance'. Added to this to be aware of the value of developing a relational understanding of the context of the trainee psychologist as well as the client. Finally to engage with the context of the client as well as to encourage therapists to explore their personal attitudes towards the topic of sexuality (Buehler, 2014).

Let's talk about sex

"What counts in the things said by men is not so much what they may have thought or the extent to which these things represent their thoughts, as that which systemizes them from the outset, thus making them thereafter endlessly accessible to new discourses and open to the task of transforming them."

- Michel Foucault (The Birth of the Clinic)

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Let's talk about sex

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Appendix A - Informed Consent

INFORMED CONSENT FORM

TRAINEE PSYCHOLOGIST

How trainee psychologists manage the first interview with a specific focus on gathering information around sensitive topics such as sexual health: a phenomenological approach and thematic analysis of trainee reflections.

You have been asked to take part in a research project which is described below. The researcher will explain the project to you. If you have any questions, Dominique Garnett, the person responsible for this study, will discuss them with you.

You are invited to participate in this study as you are currently a trainee psychologist undertaking a first interview exercise and currently a student in the Psychology Masters Program. The purpose of this research is to explore how trainee psychologists gather a complete psychosocial history of a new client including sensitive topics such as sexual health. We are interested in trainees' challenges with such sensitive topics and the affect on the working alliance between clinician and client. The study aims to explore how this part of the initial interview may be challenging as well as how trainees deal with and overcome these moments.

It is hoped that the knowledge generated by this study will assist in informing future training of psychologists. The information gained may assist in terms of anticipating possible challenges trainees might encounter and equipping them with the skills necessary to effectively resolve these issues.

The interview will be transcribed for analysis purposes; however, all identifying information will be removed.

Your participation is voluntary

You may choose not to participate or you may discontinue your participation at any time without penalty or disadvantage to yourself

The records of this study will be kept private

No personal identifying information will be used

Let's talk about sex

The recording of the interview will only be used for research purposes

Should any material be personally distressing, provision will be made for counselling

This project is supervised by Mr. Sachet Valjee. The researcher has applied for ethical clearance from the Ethics Committee, should this be declined none of the records will be used for the research.

Should you have any further concerns at any stage of the research process please contact Dominique Garnett or Mr. S. Valjee

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Your signature indicates that this research study has been explained to you, that your questions have been answered, and that you agree to take part in this study. You will receive a copy of this form.

Subjects Name: _____

Signature of Subject

Date

Appendix B - Declaration

Declaration

Date:

Name & Surname:

Student Number:

Permission to obtain audio recording of my interview which will be used for research purposes
by Mrs. Dominique Garnett:

I hereby consent / do not consent to have this interview recorded

Signature of Participant:

☐

I have read and signed the consent form

☐

I have read and understood the Declaration

☐

I have been informed of my rights and terms of confidentiality regarding this research

Signature of Participant:

Appendix C - Semi-Structured Interview

Theme 1: Knowledge of Interview Process and Content

Question 1: What was your experience when conducting a first interview with a new client?

Probes: Orienting the client to therapy process; client's expectations of therapy; your understanding of dealing with sensitive subjects.

Question 2: Do you think that you were adequately prepared for the process of conducting an initial interview with the goal of acquiring a person's psychosocial history?

Probes: Familiarity with process; understanding the process; personal challenges around sexual health; did these either help or hinder the process?

Question 3: How did you introduce your client to the topic of sexual health during the first interview?

Probes: Understanding the purpose of sexual health information - client and clinician; anxiety; prejudice; stereotypes; value judgments.

Question 4: Can you describe the moments that initiated any discomfort that was perceived?

a. By you as the clinician

b. By your client

Probes: Expressed verbally or non-verbally: expressed by gestures, facial expressions, gait;

Question 5: What would you ascribe as to having precipitated some of the above mentioned reactions from you or your client?

Probes: In relation to: effects of culture, gender, effects of language differences, working alliance and disclosure

Question 6: How do you think these aspects influenced the client's disclosure of his/her disclosure of their sexual health?

Let's talk about sex

Probes: Invasion of privacy; presenting reason for therapy: assist or hinder questioning around sexual health; conflicting value systems.

10.1.2. Theme 2: The Working Alliance

Question 1: Considering the discussion above, what were the aspects or moments that you were aware of having an effect on the working alliance (for example rapport, trust, feelings of comfort)?

Probes: Skills used to create good rapport; preparation; orientation; anxiety.

Question 2: At the time of inquiring about sexual health what were your thoughts about the working alliance and rapport between you and your client?

Probes: Ruptures within the working alliance; repairing ruptures; personal issues affect your ability to maintain the working alliance?

Question 3: Once you have inquired around sexual health, immediately following how did you perceive the working alliance?

Probes: Knowledge and skills to draw on; framing the topic of sexual health; maintaining the working alliance?

10.1.3. Theme 3: Overcoming obstacles

Question 1: What strategies did you employ to help deal with the obstacles that you experienced?

Probes: Theoretical training; personal paradigm

Question 2: What were your expectations when covering sensitive topics during the first interview?

Probes: anxiety; avoidance; rushed; overlooked; ease

Question 3: What would you do differently when broaching the topic of sexual health?

Probes: Preparation; orientation to therapy; more direct questioning; addressing discomfort

Let's talk about sex

Question 4: What do you think would have been helpful within your training to equip you to deal with sensitive topics such as sexual health?

Probes: More experience; better training; more role plays; personal issues needing attention;
personal attributes

Appendix D - Morrison Interview Schedule

Taken from Morrison

Appendix A

Summary of the Initial Interview

Information Process

Openings and Introductions

Introduce yourself Explain your role in patient's care Outline time, goals of interview

Your initial goals Teach respondent role to patient Help patient feel comfortable

Chief Complaint

Ask why patient came for treatment Request for chief complaint is directive but open-ended

Free Speech

Allow several minutes for patient to amplify on reasons for coming Listen for areas of clinical interest Difficulty thinking (cognitive disorders) Substance use Psychosis Mood disorders (depression and mania) Anxiety, avoidance behavior, and arousal Physical complaints Social and personality problems Summarize presenting problems before moving on

Early part of interview is nondirective Establish rapport Adjust your demeanor to patient's needs

Monitor your feelings Show your positive affect clearly Use language patient can comprehend

Don't criticize patient or others Maintain appropriate distance Don't talk about yourself Call patient by title and last name Encourage flow with silent encouragements Maintain eye contact Nod or smile when appropriate Verbal encouragements "Yes" or "Mm-hmm" Repeat patient's own word or words Ask for more information Re-request information if patient doesn't respond at first Briefly summarize

Reassure patient when indicated Must be factual, believable Use body language Correct any misconceptions about physical, mental symptoms

History of the Present Illness

Describe symptoms Type Onset and sequence Severity Frequency Duration Context Stressors Vegetative symptoms Sleep Appetite and weight Diurnal variation Previous episodes When? What symptoms? Recovery complete? Previous treatment Type Compliance Wanted effects Side

Let's talk about sex

effects Hospitalizations Consequences of illness Marital and sexual Social Legal Job (disability payments?) Interests Discomfort Feelings about symptoms, behavior Negative and positive How does patient cope with feelings? Defense mechanisms Acting out Denial Devaluation Displacement Dissociation Fantasy Intellectualization Projection Repression

Establish the need for truth It's for patient's benefit and for yours Reassure about confidentiality:

"If you can't discuss something, don't lie; just ask to talk about something else" General principles Restate what patient says to be sure you understand Don't phrase questions in the negative Avoid asking double questions Encourage precision Keep questions brief Watch for new leads Use terms patient can understand Probe for details Use direct questions Avoid "Why . . ." questions, as a rule Limit to one to two confrontations, late in session: "Help me to understand" Mix open- and closed-ended requests Open-ended increase validity Closed-ended increase information Elicit feelings best with Uninterrupted speech Open-ended questions—"Could you tell me more about that?" Direct requests for feelings—"Tell me about your depression" Also obtain feelings with: Express concern or sympathy—"I'd feel angry, too" Reflection of feelings—"You must have felt frantic" Watch for emotional cues in voice, body language—"You looked sad just now" Interpretations—"Sounds like the way you felt as a child"

THE FIRST INTERVIEW

Information Process

Splitting Reaction formation Somatization Explore areas of clinical interest

Analogy—"Did you feel this way when your mother died?" Reduce excessive emotionality Speak softly yourself Closed-ended questions Redirect comments that change topic Re-explain what information you need Ask whether patient understands what you want to know Break off interview only as last resort

Personal and Social History

CHILDHOOD AND GROWING UP Where was the patient born? Number of siblings and sib position Reared by both parents? How did parents get along? Did patient feel wanted as a child? If adopted: What circumstances? Extrafamilial? Health as a child? Education Last grade

Let's talk about sex

completed Scholastic problems? Activity level? School refusal? Behavior problems in school? Suspension or expulsions? Sociable as child? Age dating began? Sexual development Hobbies? Interests?

LIFE AS AN ADULT Living situation Currently with whom? Where? Finances Ever homeless? Support network Family ties Agencies help out? Marital Number of marriages Age at each

Take charge of interview Encourage shorter answers with nods and smiles Directly state when you need to know about something different, but . . . Make an empathic comment first Raise a finger to interrupt Stop taking notes If steps above don't work: Be direct: "We'll have to move on" Use more closed-ended questions Use multiple-choice questions Transition to new topics Use patient's own words Acknowledge an abrupt transition: "Let me change the subject, now"

Watch for distortion Record significant negatives

DEALING WITH RESISTANCE Do not allow yourself to become angry Switch from discussing facts to feelings Reject the behavior, accept the person Use verbal and nonverbal encouragements Focus on patient's interests Express sympathy Reassure patient: Feelings are normal Emphasize need for complete database

Information Process

Problems with spouse? Number of children, age, and sex Stepchildren? Work history Current occupation Number of jobs lifetime Reasons for job changes Ever fired? Why? Military Branch, years of service Highest rank attained Disciplinary problems? Combat experience? Legal problems ever? Civil History of violent behavior Arrests Underlying feelings Religion: Which? Different from childhood? How religious now? Leisure activities Clubs, organizations Hobbies, interests Sexual preference and adjustment Learning about sex: details First sexual experiences Nature Age Patient's reaction Current sexual preference Current practices: details Pleasures Problems Birth control methods Extramarital partners Paraphilias? Sexually transmitted diseases? Abuse? Childhood molestation Rape Spouse abuse

Substance misuse Type of substance Years of use Quantity Consequences Medical problems Loss of control Personal and interpersonal

Let's talk about sex

Name the emotion you suspect patient is having If patient is silent, obtain nonverbal response
first Focus on less affect-laden model of patient's behavior If confrontation is used:
nonjudgmental, nonthreatening Last resort: Delay the question

RISKIER TECHNIQUES Offer an excuse for unfavorable information: "All that stress probably
made you want to drink" Exaggerate negative consequences that didn't happen: "Nobody died,
did they?" Induce patient to brag "Any activities for which you could have been arrested, but
weren't?"

"Please tell me about your sexual functioning"

Lead into questions of abuse carefully: "Were you ever approached for sex?" Avoid terms abuse
and molestation Assume that all adults will drink some Ask about past as well as current use

THE FIRST INTERVIEW

Information Process

Job Legal Financial Misuse of prescription medications? Suicide attempts Methods
Consequences Drug or alcohol associated? Psychological seriousness Physical seriousness
Personality traits Evidence of lifelong behavior patterns

You can work up to this gradually: "Have you ever had any desperate thoughts? Any ideas of
harming yourself?"

Assess personality by Patient's self-report Informants History of interaction with others Your
direct observation

FAMILY HISTORY Mental disorder in close relatives Describe parents, siblings, and patient's
relationship with them Other adults, children in childhood home "Has any blood relative-parent,
brother, sister, grandparent, child, aunt or uncle, cousin, niece or nephew-ever had any mental
illness, including depression, mania, psychosis, mental hospitalization, severe nervousness,
substance misuse, suicide or suicide attempts, criminality?"

MEDICAL HISTORY

Major illnesses Operations Medications for nonmental problems Dose Frequency Side effects
Allergies To environment To medications Nonmental hospitalizations Childhood physical,
sexual abuse? Risk factors for AIDS? Physical impairments

Important for all mental health workers to obtain

REVIEW OF SYSTEMS

Disorders of appetite Head injury Convulsions Unconsciousness Premenstrual syndrome

Specialized review for somatization disorder

Positive responses in these areas have especial relevance to mental health diagnoses

Appendix B

Information Process

Mental Status Exam

Appearance Apparent age Ethnicity Body build, posture Nutrition Clothing: Neat? Clean? Style?

Hygiene Hairstyle Body adornments, jewelry? Alertness: Full? Drowsy? Stupor? Coma? General behavior Activity level Tremors? Mannerisms and stereotypes Facial expressions Eye contact

Voice Attitude toward examiner Mood Type Lability Appropriateness Intensity Flow of thought

Word associations Rate and rhythm of speech Content of thought Delusions Hallucinations

Anxiety Phobias Obsessions and compulsions Suicide and violence

Orientation: Person? Place? Time? Language: Comprehension, fluency, naming, repetition, reading, writing Memory: Immediate? Short-term? Long-term? Attention and concentration

Serial sevens Count backwards Cultural information Current events Five presidents (prime ministers)

Observed while taking history

“Now, I’d like to ask some routine questions . . . ”

“How has your memory been? Do you mind if I test it?”

THE FIRST INTERVIEW

Information Process

Abstract thinking Proverbs Similarities and differences Insight Judgment

Closure Summarize findings Set next appointment “Do you have any questions for me?”

Appendix E - Transcriptions

Participant 1

BEGIN: BRIEF INTRO AND SMALL CHAT

Introduce the Topic: Sexual History and Sexual functioning during intake interview. Gathering information

Interviewer:

So what was your experience when conducting a first interview with a new client so not just in terms of sexual history, how did you find that intake with a new client.

Participant 1:

For me being the first time I felt a bit anxious, I felt a bit all over the place even though I had structure.

Interviewer:

Did you have the sheet in front of you?

Participant 1:

Yes I did but just as a guide. I didn't write down as I was going I just found that distracting, I didn't know how they would find it but at the end of it I did get through everything and it went a lot quicker than I thought. I thought it was going to be this long dreary process in actual fact it wasn't, I guess it just depends on the client as well as to what's going on.

Interviewer:

So when your client comes in for the first time do you go through an orientation to therapy, about what you're doing? So what is the type of thing you would say to a client?

Participant 1:

Yes. For me I just say I'm a training psychologist and with therapy, I can't get my words right here, depending what their presenting problem is they are going to say to me, I say to them ok this is what I'm thinking. I always have a plan in which direction I want to go in and then I either explain what therapy will be done, most the time I repeat it, at the beginning and at the end again so they make sense of it.

Interviewer:

And do you let the client know that you will be covering things that might be a bit awkward?

Participant 1:

Yes I do say that some things might be a bit sensitive and they might be a bit uncomfortable at times but they must be honest and open, and not talk about things that are too uncomfortable at that moment.

Interviewer:

Ok, so you do try and prepare them that you are doing a full history.

Participant 1:

Yes, yes I do.

Interviewer:

Do you think you have been adequately prepared for that interview and the fact that you are dealing with a sensitive topic?

Participant 1:

Honestly no, I wish there was more practice, we did do practice rounds but.....

Interviewer:

Role-plays?

Participant 1:

Yes, I wanted more, I did take my own initiative to do things but I would have liked more feedback from other lecturers.

Let's talk about sex

Interviewer:

So when you did role-play did you cover these sensitive topics such as sexual functioning, sexual history?

Participant 1:

We did speak about it but everyone was wanting to avoid it, so we just said let's make it easy, we won't make it awkward or anything like that.

Interviewer:

So that part of the interview was overlooked? So did all of you have a similar feeling?

Participant 1:

Yes, from what I can guess, yes we re-watched it in class, we didn't focus on that either, so I wasn't really sure, we did mention it in class.

Interviewer:

So it seems like it's almost a taboo subject, pushed to the side?

Participant 1:

Yes, yes.

Interviewer:

So your familiarity with the process and understanding the process, so you're getting familiar with what is expected with an intake interview? Your own personal challenges around sexual health, do you think that inhibits you or helps you, or your own feelings towards sexuality.

Participant 1:

For me I'm a very closed person, it's not something I will talk about to anybody so for me it is a bit of a challenge, so I don't want to talk about it. So how can I expect someone else to talk about it? But I know it is something that has to be done so it's a work in progress.

Interviewer:

So that's quite difficult because it's a challenge for you and you know you have to do it?

Participant 1:

Yes it is but depending what's going on I'll sometimes link it with something else and incorporate it so it's not so uncomfortable for me. Not that I'm the first one to bring it up but it doesn't always work out that way. It is always in my mind.

Interviewer:

So then when it comes to things like drug use do you feel more comfortable talking about that kind of sensitive topic?

Participant 1:

Yes I do, I feel happy with that kind thing, I think just because of my own personal history with family members that have gone through this sort of thing, so for me I wish that people would be open and talk about it, so for me this is fine as well as suicide so I'm comfortable with that.

Interviewer:

So it's just around the sexuality? So does it help to know the reason for asking about sexual health?

Participant 1:

Yes

Interviewer:

Do you feel it has been explained adequately in your training as to why you are even asking that?

Participant 1:

Honestly, not really, I have to do my own asking, but if I had to go on what's said in class, no not really.

Interviewer:

So you've just got this piece of paper with a sort of sexual history and sexual functioning, so you ask well why exactly? Is that the feeling about it?

Let's talk about sex

Participant 1:

Yes, Yes.

Interviewer:

So if you could avoid it you would?

Participant 1:

Yes I would.

Interviewer:

So at what point do you think it would be relevant to a case or to a client?

Participant 1:

Well it does depend on the presenting problem because you never know sometimes if someone is very anxious because of some sexual abuse history but it does depend on what one is presented with, but it's always in the back of my mind and it does link in when you don't even think about it.

Interviewer:

So it's difficult to know when you need to question when it's relevant.

Participant 1:

Yes.

Interviewer:

But if you had your choice you would rather not deal with it.

Participant 1:

Yes.

Interviewer:

So in your intake interview and you have had to question around sexual functioning and sexual history, are there moments of discomfort that you have picked up, either for you or for your client.

Participant 1:

Yes actually one of the recent ones, he is a similar age to me, I felt uncomfortable and I think he did as well because he had this nervous laugh and didn't make eye contact with me, he looked away, so obviously he was uncomfortable and for me on my side as well, I don't know if it was me or because of his reaction I felt uncomfortable. It seems better when it's someone older than me, I am uncomfortable but they seemed fine about it, also younger I am fine.

Interviewer:

How much younger? Teenager?

Participant 1:

Yes early teens.

Interviewer:

So it's more your age?

Participant 1:

Yes.

Interviewer:

So why do you think that is?

Participant 1:

I'm not quite sure why.

Interviewer:

And if it was a similar age and female would it have been easier?

Participant 1:

Probably I think basically because it was male so it was just that much more uncomfortable, I know he is straight and has a girlfriend so it was like crossing boundaries.

Let's talk about sex

Interviewer:

So you don't perhaps want him to feel that you are stepping over the line asking him things that are uncomfortable for him and you. But the interesting thing he that he is sitting with you talking about intimate things not necessarily about sexuality but that's what comes into the room with us anyway, isn't it? That whole gender stuff.

So what would you ascribe to having precipitated some of the abovementioned reactions from your client, the awkwardness, was it the gender thing and age?.

Participant 1:

Yes definitely the gender and age.

Interviewer:

And was he the same race as you?

Participant 1:

No different race.

Interviewer:

And do you think that had any bearing on it at all?

Participant 1:

From my side no.

Interviewer:

So it's more male and a similar age? So the race group didn't have any significance on it at all?

Participant 1:

No not at all.

Interviewer:

So talking about that then if you think about it in relation to culture, gender and language and religion what would be the things that would stand out for you that would make it more awkward and difficult.

Participant 1:

I would say the gender again and being of a similar age, the older ones ok and younger I'm fine. Culturally and religion no, I don't have a problem with that.

Interviewer:

So how do you think that these aspects for instance, that previous man, it now came up, it's on your sheet and you now have to get through it... how do you think that influenced that client's disclosure to you, how you were?

Participant 1:

I think it made it awkward and tense for that moment but after that he was open to answering things I think it was just to get over that bump and carry on and then it was fine.

Interviewer:

So what is it about asking around sexuality that makes it difficult? As you said you don't want to talk about your own sexual stuff, you don't want other people to feel pressurised into talking about that? Is it an invasion of privacy?

Participant 1:

For me it is a private thing, in my background just growing up it was a very closed about all this sort of thing, so I feel that way as well so how can I expect someone else to disclose all this information to me.

Interviewer:

Yet we expect as clinicians our clients to be disclosing a range of things which are really difficult.

Participant 1:

Yes it is true.

Interviewer:

Let's talk about sex

So why do we separate that, i.e. somebody can sit and tell you, "I was abused as a child" or "I use drugs and nobody knows" and that's intimate because they haven't shared it with somebody, and we are happy to talk about that stuff but as soon as it comes to sexual health, sexuality, sexual functioning, sexual history we shy away from it, why do we do that?

Participant 1:

One can't blame the media, it's more in your face than ever, I think it's a personal thing.

Interviewer:

So with you and your family how was sex discussed? In the home was it discussed?

Participant 1:

In the home it was discussed once and that was it. Even when it was discussed at school I hated it, that was just my personal feeling.

Interviewer:

So this is what we learn about, what are we bringing into the room all the time, it has to come from somewhere, interesting. Were you aware of discussing a sensitive topic like sexuality affecting the working alliance at all or not? Perhaps it didn't, were you aware of it, as you mentioned there was a moment of awkwardness.

Participant 1:

Yes there was but I didn't want to dwell on it as to what he was thinking so I just moved on.

Interviewer:

So what skills did you use to create a good rapport basically, the preparation and orientation? How did you manage your anxiety then?

Participant 1:

I do a lot of prep work, I run through the questions beforehand and I make sure of exactly what I want to say and comfortable of what I want to say, yes it's a lot of prep work for me.

Interviewer:

What happens when someone sits down in front of you saying that he has erectile dysfunction?

Participant 1:

I try to just keep calm do a history and then ask the questions as to when did it start, when did you start noticing it.

Interviewer:

Is that uncomfortable for you?

Participant 1:

No, because if it is a presenting problem I don't have an issue with it, they have brought it forward so I'm going with it, compared to the sexual thing, if I brought it up then I'm uncomfortable.

Interviewer:

So for you there is a difference. So in the event you are actually putting it on the table then you feel that perhaps it's an invasion of their privacy whereas if they are coming with that kind of problem, is it different for you?

Participant 1:

Yes in my mind I think, ok they have brought it I just need to click in and go with it.

Interviewer:

So the difficulty is actually you bringing it up, but there isn't an issue with drug abuse, alcohol abuse when you bring it up?

Participant 1:

Yes that's right.

Interviewer:

Let's talk about sex

So what strategies did you employ to help deal with the obstacles that you experience, so basically that awkward moment, what did you do exactly to move beyond this moment?

Participant 1:

I just move onto something I'm more comfortable with.

Interviewer:

So you just use the structure that is in front of you, just moving through onto the next thing, and is that quite comforting to have that structure?

Participant 1:

Yes, I have that as a guide, so yes I do find that helpful.

Interviewer:

Do you think that asking about sexual history or sexual functioning in the intake interview there is the awkwardness; do you think that if you had seen a client for 3 or 4 sessions it would be easier or do you think you would still feel a bit of anxiety around it?

Participant 1:

I would still feel the anxiety but I think it would be a bit easier because you're establishing a relationship with that person so it's not like the first time you're dealing with a stranger and they have to tell you all these things. So I think as time goes on it is easier but for myself I will still feel anxious but this is because of my personal feelings about it but as time goes on it will be easier.

Interviewer:

So if there was a good working alliance and the rapport was good you would feel more comfortable to be able to speak about that regardless of your own personal feeling about it and if that person in 3 or 4 sessions needed to speak about their intimate sexuality what they do what they don't do and how often, and this person is the same age, do you think you will still feel anxious?

Participant 1:

I probably will but again if it's their need I will be able to deal with it, the anxiety will be there but it will be fine to deal with.

Interviewer:

So let's say the scenario is you've done the intake interview, sometimes it will take 2 sessions so let's say after your 2nd session you haven't covered anything about sexual health and sexual functioning, sexual history, now it's your 3rd session do you feel that you would think now I need to get to this part of the person or do you think you would leave it and see if it comes up as part of the issue.

Participant 1:

I don't think I will be able to leave it because I know I will have to cover this so I will have to bring it up.

Interviewer:

So how is your theoretical training and your own person paradigm how does that effect how you are in therapy around sexual matters? So your theoretical training is the area of theory of understanding of 'why I'm asking about this' [sexual health].

Participant 1:

No I would have to do my own research and reading.

Interviewer:

There hasn't been too much understanding of 'why I'm actually asking' and why it's an important part of a person's functioning. Is that right? And then your own personal paradigm like you said, when at school you didn't really feel comfortable about discussing it, so this influences your process in therapy?

Participant 1:

Yes.

Interviewer:

Let's talk about sex

So again it's very interesting as there is this person that literally is going to expel all this information about themselves and there is this worry of yours on the one side: again why do we do this? This is exactly what the research is looking at, why do we do this? Why do we separate it? We want people to tell us all these other really intimate things about themselves, why do we keep that so separate? Keep this thought in your head, what are we doing then, why is that an issue? Is it society? Is it our religious understanding?

So what were your expectations when covering a sensitive topic, were you very anxious about it, quote "it's always in the back of my head" unquote, is this always the feeling of saying: "I have to get to this"?

Participant 1:

Yes in this moment in time, yes.

Interviewer:

So when you have an intake do you feel a bit of anxiety around knowing that? So there's this side of the interview and that side of the interview and then there's the middle stuff that I have to do?

Participant 1:

Yes

Interviewer:

So you feel anxiety, do you avoid it? Do you probe it? Do you overlook it?

Participant 1:

No I don't probe it. I will ask basic things and then feel that's enough and then move on. I spend as little time on it as I can, but again it's from my side, I don't dwell on it for a long period of time in the interview.

Interviewer:

Ok, let's say I come into see you and I tell you I'm having a terrible time with my husband and our relationship has just become really bad. Do you think that will flag a little bit more - my sexual functioning, or would also like to rather probe around the other topics and leave that?

Participant 1:

It would flag for me with relationships but it won't be something that I would start with straight away. I would look at other things and then come back to it.

Interviewer:

So it wouldn't be a big part of asking me about my sexual history?

Participant 1:

No

Interviewer:

So obviously we have had a discussion now so you're thinking maybe a little bit differently? What would you do differently? I'm not saying this as an intervention, I'm just saying that with us chatting because you can't see it without it... if you look back at your intake interviews is there anything you would do differently when broaching this topic? Or are there other skills or tools you could use?

Participant 1:

It's more on me, I have to become more comfortable with it and with more time and practise it's ok to ask people about this. I think over time it will be fine, it's all on my side to deal with my anxiety.

Interviewer:

And also perhaps orientation, so basically being able to say to your client, "I'm looking at you as a whole person, this being you as a sexual being, you as an emotional being, you as a physical being so I'm going to be asking questions around all those things to get a complete picture of you so perhaps that can also just assist? As in right in the beginning 'you're a whole person', where at the moment I don't think we

Let's talk about sex

see the whole person, you're pushing that to the side, we are all sexual beings, so the question is why do we do this? Is it culture, is it gender, is it age, what affects us not being able to do that?

What do you think would have been helpful in your training to equip you better when dealing with sexual health?

Participant 1:

I would say throwing us into the deep end, practising on each other, confronting it head on and also more reasoning as to why we ask these specific questions.

Interviewer:

So what info as to why sexual health is important. This year do you have any lectures on sexual health?

Participant 1:

No

Interviewer:

So would more role- plays help around this kind of thing?

Participant 1:

Yes, specifically on sexual history.

Interviewer:

Do you struggle with finding the words to use?

Participant 1:

No not really I have my prep questions that I don't deviate from. What is difficult though is sometimes a client might say "what do you mean by that" then you have to explain more. So then you have to watch your words, you don't want to say anything wrong or take it in a different direction. Having to speak more about it just makes me more uncomfortable.

Interviewer:

But do you think if you practised that more like in a role- play and more discussions within the class of using those specific words would that make it a bit easier?

Participant 1:

Yes

Interviewer:

Is there anything else you would like to add specifically with things around culture, gender, age or expectations? Like you said when you were sitting with that male client that is of a similar age to you, you didn't want him to feel you were crossing boundaries. So what's the expectation there, what could he be thinking that you are worried about boundary?

Participant 1:

I just think people generally get together when they're near similar ages, so this is going through my mind, not that I have any expectation to date the client.

Interviewer:

So is it the expectation that if you're talking about sex that he might think that it's an invitation?

Participant 1:

Yes, I think it's me and how I have grown up and how I've learnt things to be.

Interviewer:

And how is that? How have you learnt things to be?

Participant 1:

Me and my family environment and my friends, nothing specific.

Interviewer:

Is it gender roles?

Participant 1:

Let's talk about sex

Yes I suppose you can say that.

Interviewer:

That maybe it's difficult for females to talk about that kind of thing?

Participant 1:

Yes I just think with my family being really closed, it's just me I don't want to talk about it.

Interviewer:

I know it's not a subject that we don't always talk about and it's difficult to be put on the spot so if you think about anything else you would like to discuss or have any questions please just send me an email.

Participant 2

INTERVIEWER:

We will start with the knowledge of the interview process and the content, so what was your experience when conducting your first interview with a new client?

PARTICIPANT 2:

The first time I did an interview I left out a lot of stuff. We had that role-play originally to practise but it's very different when you have a real client. After 40 minutes of the second session you start developing a bit of a rapport with the client.

INTERVIEWER:

So do you go through the process of orienting your client to therapy and how it's going to work and what to expect?

PARTICIPANT 2:

Yes I do follow the form and tell them it's going to be a process of asking questions and to be as honest as we can be.

INTERVIEWER:

Do you discuss how you will be covering sensitive topics in that orienting phase?

PARTICIPANT 2:

I guess it does get them thinking not that it will put them on guard as to what they should say even on not sensitive stuff, so we will just be as honest as we can and then go from there.

INTERVIEWER:

So do you think you were adequately prepared in training to deal with all history including sexual functioning?

PARTICIPANT 2:

Yes with all training and practising I'm comfortable with it but when it gets to issues around sexual history and suicide and that kind of sensitive stuff I'm not comfortable with it. I don't know how to broach the subject especially if it's a female. Especially if she is much older.

INTERVIEWER:

When you did your role-plays and went through all these different things: drug abuse, alcohol abuse, suicide ideation, sexual functioning, sexual history, did you practise that or was it glossed over in the role-play?

PARTICIPANT 2:

Well we had our form we went through each section: alcohol, drugs and even suicide. I was comfortable but when we got to that section I felt uncomfortable about talking about all that sensitive stuff. Even asking about sexual history was difficult. I got to that part of the interview and didn't know how to ask her.

INTERVIEWER:

Let's talk about sex

So how did you ask her?

PARTICIPANT 2:

I am still not actually sure what is the correct way of doing it.

INTERVIEWER:

So you used it on your form, as it was? You asked the question, ticked the box and moved on?

PARTICIPANT 2:

When I asked about sexual functioning I asked about libido levels and in role-plays we just kind of practiced how to act. I asked about sexual interest and whether they were involved in pleasurable activities. But I felt awkward.

INTERVIEWER:

What makes it awkward?

PARTICIPANT 2:

I know so little about the person on the other side and I am asking incredibly personal questions, which I don't know how to phrase it right and I don't want to cause disrespect. Especially thinking about my client. If the person was my age it might be a lot easier. Maybe it's because of my background. Talking about this is just not something that happens.

INTERVIEWER:

Are you saying that it's because of how you were raised? Is it cultural?

PARTICIPANT 2:

Basically yes, that's how it is in my family, we don't talk about it....sensitive stuff like that.

INTERVIEWER:

So your mum didn't speak to you about sex, or your dad only speaks to the boys...what are the rules in the home?

PARTICIPANT 2:

There's no like formal talk, my dad just once told me this....that if you have met a girl...you have got to grow up safe. He didn't even use the word 'sexual', like mention anything, just brief

INTERVIEWER:

So the topic is just quiet vague?

PARTICIPANT 2:

It's like I can't talk to him and then he's embarrassed and it's like....

INTERVIEWER:

So then you are sitting with a client and you have to gather all this history and you have to ask this as well. Do you think that gender is an issue for you...that it may be easier to talk to a man?

PARTICIPANT 2:

Yes definitely

INTERVIEWER:

So talking to a woman like me is a little bit more difficult to broach the subject?

PARTICIPANT 2:

Yes definitely

INTERVIEWER:

And why do you think that is?

PARTICIPANT 2:

Because maybe as a male to male we can like relate because we've got the same sort of opinion. I mean this is generalisation but....because as guys we would have the same kind of opinions and ideas about sex and obviously that differs greatly from females so with a male there is that sort of connection

Let's talk about sex

before. So it's more familiar, it's easier for us to, there's the same knowledge. Talking to a female it's like crossing a boundary.

INTERVIEWER:

Tell me more about the boundary

PARTICIPANT 2:

It's kind of like....because our perceptions are different between males and females and so I feel uncomfortable because I don't know what it's like to be on the other side and I don't want to cause offence.

INTERVIEWER:

So what concerns you about the boundary?

PARTICIPANT 2:

I need to think about this.....

INTERVIEWER:

Because I am thinking that we are happy to ask people about how much do you drink, are you taking medications that are not prescribed by your doctor? ...I mean those are quite intimate things....do you have thoughts about killing your mother....those are intimate things. Those are possibly things that a person would never speak to anybody about yet the minute we ask 'what is your sex life like'...what happens?

PARTICIPANT 2:

I think that they would feel that I am judging them, if you know what I mean? You know like that whatever they say it would be putting on a way that was socially acceptable. But if it is man to man then that wouldn't be as much of a problem because you could just talk about it, whatever they are experiencing.

INTERVIEWER:

So is your concern then that a female client might feel that talking about sex might mean judgement on your part to me[as the client]?

PARTICIPANT 2:

I would think that's what they would be thinking

INTERVIEWER:

And that is your concern?

PARTICIPANT 2:

Yes and whether they can trust me to be judgement free and also about my reaction

INTERVIEWER:

So that's interesting that there seems to be a gender issue the minute we talk about sex or sexuality?

PARTICIPANT 2:

Yes definitely

INTERVIEWER:

Ok. So then does it help to have a better understanding of sexual health, sex under the umbrella of sexual health and to understand the relevance of 'why am I asking this'?

PARTICIPANT 2:

Yes it does

INTERVIEWER:

Do you feel you have that information? Or do you sort of look at it and wonder 'why do I have to ask this?'

PARTICIPANT 2:

Let's talk about sex

I don't know exactly why we need to ask it...I know there is a point to it. Especially when we are looking at normal behaviours or compulsive behaviours....I can understand that it is necessary to know but I mean I haven't really read any formal literature about that...it's just me thinking off the top of my head. I would think it would be quite useful but.....

INTERVIEWER:

But you are still not convinced that...

PARTICIPANT 2:

I think it would be relevant to ask if you had other information that said this is what you needed to ask...but to have to ask everyone this..... It kind of needs to be an optional thing, like if the previous answer is yes then you ask this

INTERVIEWER:

Ok so do you feel the same about suicidal ideation?

PARTICIPANT 2:

I feel the same about suicidal ideation. I would only ask the question if the person had a history of depression but I would still ask it

INTERVIEWER:

So you are more likely to ask about suicidal ideation and tick the box that you asked about that but not about sexual history and sexual functioning?

PARTICIPANT 2:

Yes

INTERVIEWER:

And do you think you would definitely always ask about alcohol and drug use?

PARTICIPANT 2:

Yes I would ask that every time

INTERVIEWER:

But sexual history or functioning you might not?

PARTICIPANT 2:

I might but I don't think I could stay there too long unless there was something very apparent Otherwise I will just go onto the next section

INTERVIEWER:

This client that you are seeing, you have seen her 4 times? And have you covered sexual history/functioning?

PARTICIPANT 2:

3 times [seen the client]. I asked 1 question, saw that it was fine and then moved on

INTERVIEWER:

And in that moment was there discomfort for you and how did you know?

PARTICIPANT 2:

I watched the video of that interview and I could see my body language was getting a bit like...

INTERVIEWER:

Stiff? [The participant had shifted in his seat at this point in the interview and looked stiff]

PARTICIPANT 2:

Yes I was sitting there like this and then I crossed my leg, I could see I was defensive and I could see in the client and she said 'everything is fine there' and we moved on

INTERVIEWER:

So you noticed in the client?

PARTICIPANT 2:

Let's talk about sex

She was reacting to my discomfort so I can't blame her...it was me

INTERVIEWER:

So you noticed a changed?

PARTICIPANT 2:

Yes because we had really good rapport going on and then it felt tense for that short period and then it went back to being normal

INTERVIEWER:

So in relation to culture, is she from the same cultural group as you ?

PARTICIPANT 2:

No, she is a white lady

INTERVIEWER:

Are you aware of culture being something in the room?

PARTICIPANT 2:

No...not really. It must have played a role.....But I think that she was much older and I am young

INTERVIEWER:

What seems to be apparent is that gender and age seems to be more of an issue....not culture

PARTICIPANT 2:

Yes definitely. And I think age even more than gender. If there is a big age gap...

INTERVIEWER:

That's interesting. So how do you think age impacted on her disclosure to you? Even though you have said you did not stay with the topic for long, you have got to know her...how do you think she would react if you raised the topic?

PARTICIPANT 2:

I think she would be ok but I think she would be guarded. I think she would only answer the question but not disclose about something that happened or....a specific experience....no

INTERVIEWER:

So when you think about asking about sex, do you think it is an invasion of privacy....

PARTICIPANT 2:

Exactly! And I know it shouldn't but that's exactly

INTERVIEWER:

And that is why I am so interested in this because why is asking about dying not an invasion of privacy but asking about sex is? Why is asking about how a person drinks not an invasion of privacy?

PARTICIPANT 2:

I think from what I have experienced from my culture and upbringing we talk about about people that have died, it's an open discussion and we talk about substance abuse and drug abuse. My dad's a doctor so we talk about some of the clients he has. We can sit around a dinner table and have an open conversation about that.

INTERVIEWER:

But you are not sitting around the dinner table talking about sex?

PARTICIPANT 2:

No

INTERVIEWER:

I don't mean about sex itself, I mean about sexual health, us as sexual beings?

PARTICIPANT 2:

No. Not even about relationships. Not even about that. My dad once told me 'out of sight out of mind'. Like choosing to not know. 'As long as you are happy then I don't mind'.

Let's talk about sex

INTERVIEWER:

What's interesting for me is we see the person as a whole, the physical person, the emotional person, but their sexual functioning we kind of push aside

PARTICIPANT 2:

Yes ...happy if you just keep it to yourself

INTERVIEWER:

Seems to be quite weird because it is everywhere in society yet no one talks about it? And we bring that into the therapy room. We are asking people to share intimate things with us yet sex is taboo. Doesn't that interest you?

PARTICIPANT 2:

Now that I think about it, it doesn't make sense. I haven't thought about it

INTERVIEWER:

That fascinates me. What is it? Is it gender, patriarchy, age, culture.....

PARTICIPANT 2:

I can understand why it does (fascinate). But you know even at school....there were no real sex education classes or anything and it was very superficial stuff. It was only when talking to your peers, not in a formal environment that you talk about it just casually and stuff

INTERVIEWER:

Yet every person engages in sex at some point, we are all in relationships, we are relationship people...people have some kind of sexual problem at some stage. I am not saying it is the be all and end all but it is a big part of us and we don't talk about it.

PARTICIPANT 2:

So even now I am thinking about things that I have thought about for the first time

INTERVIEWER:

Yet there is this expectation that we must all be in relationships. We must know how to satisfy our partner and know everything about a good relationship yet no one talks about this. Looking at the working alliance, you mentioned that you were aware of a moment of discomfort. Were you thinking about the working alliance?

PARTICIPANT 2:

Yes because even when I asked the question I was, in my mind, thinking that this could cause us to be uncomfortable in our working relationship so let me make it as painless as possible so we can get back into being

INTERVIEWER:

So you potentially saw that asking around sex may risk the working alliance?

PARTICIPANT 2:

Yes that this could cause her potentially to feel uncomfortable so I need to be careful with what I am doing

INTERVIEWER:

What skills did you use to build good rapport? Was it preparation, orientation? How did you manage your anxiety and what personal skills did you use to get through that brief period of asking about sexual history?

PARTICIPANT 2:

Not training....and no prior knowledge. If there was a training seminar on how to broach the subject of sensitive issues, even if it is just to make you think. There is just nothing to draw on

INTERVIEWER:

What were your expectations about having to ask about sexual health?

Let's talk about sex

PARTICIPANT 2:

To be honest she reacted exactly how I expected her to and gave me the answer I had expected. Even though she (the client) had mentioned that she had been sexually abused as a child, when we got to that section of the interview she answered I knew there would be minimal response and it was a minimal response.

INTERVIEWER:

Do you think knowing that there is a history of sexual abuse, and the fact that she glossed over that and just gave you the bare minimum, do you think that that there needs further looking at ...

PARTICIPANT 2:

Definitely I mean she has had sexual abuse and sexual history so it has to be important surely? I feel like, I mean if you think about it logically.....And although she has had sexual abuse it is very hard to see how that affected her from there to now? And I still don't know how to bring it up, like current life, childhood, how that affects sexual life and if it did.....

INTERVIEWER:

It's difficult because I would feel uncertain : do you want to revisit this thing, is it important to bring it up or not? Do we need to look at current sexual functioning? Does current sexual functioning link to that? What to bring up first? It's tricky. What would you do differently with a new client?

PARTICIPANT 2:

Il have to be more comfortable with being able to ask about sexual health and their experiences

INTERVIEWER:

What do feel would be helpful in better equipping you with dealing with this topic?

PARTICIPANT 2:

Definitely one or two seminars on the topic and gender stuff of being able to talk to male and female colleagues, text books or articles, something about talking about the subject because I haven't read anything useful

Participant 3

Interviewer:

Looking at how well we are prepared and how well we deal with sensitive topics specifically gathering sexual history, sexual functioning information. So I have a semi structured interview so I have a few questions as a guide so if there is anything you would like to add please feel free to do so. So if we look at the knowledge and interview process and content as a whole, what was your experience with conducting an interview with a new client?

Participant 3:

I felt it was very overwhelming .

Interviewer:

What exactly about it was overwhelming?

Participant 3:

I think that the client had so many issues and I felt that I needed to get structured information down and I wasn't getting into it because she had so many issues and she just kept on going and I wanted to draw her back so to contain was really difficult.

Interviewer:

And also to go through that, all you had to gather?

Participant 3:

Let's talk about sex

Yes, so that was actually difficult to try and fit that all in and bring her back to more structured questions and contain her at the same time.

Interviewer:

So did you go through a process of orienting your client to the whole initial intake, what it's going to entail specifically regarding sensitive topics?

Participant 3:

I just said that some of the questions might seem irrelevant or might seem strange, I didn't use the word 'sensitive' at all.

Interviewer:

So that was your way of making the client aware that you were going to gather a whole range of information?

Participant 3:

So I think 'strange' was probably the word I used.

Interviewer:

So in your mind was that an umbrella the sensitive topics you would have to cover ?

Participant 3:

When I look at it now, probably not, when I look at sensitive topics now perhaps I should have added the word 'sensitive' as well.

Interviewer 3:

So do you think you were adequately prepared for that initial interview with gathering all information?

Participant 3:

I do have to stay that I have worked before in crisis counselling but this was very different because there it was more a sexual assault unit so it was very different, it was a more structured questionnaire. I don't think you are every adequately prepared or feel confident enough so at the back of your mind you're always thinking I have to remember to ask certain questions so you lose focus a bit.

Interviewer:

So did you feel you had familiarity with the process of what you needed to say?

Participant 3:

Yes absolutely!

Interviewer:

Your own personal challenges around the topic of sexuality, sexual functioning, sexual history, how does that come into play when and if you asked?

Participant 3:

I think it was really easy for me to ask because I have worked in the sexual assault unit so it's no longer a sensitive topic for me so it's something I just would have asked. In saying that when I did ask the question I did notice that the client was taken aback, which did make me think that this was probably sensitive.

Interviewer:

So how did you introduce your client to the topic of sexual health during the first interview?

Participant 3:

I just went through the process of the questionnaire almost like being step 1, step 2, step 3.

Interviewer:

So for you is there an understanding of why you need to gather information around sexual health, sexual functioning and sexual history?

Participant 3:

Let's talk about sex

Absolutely I think that it's really important because for example a client would be going through a difficult relationship so then it shows that she's lost interest, but she's the same also, she is post diagnosis for PTSD so it was quite important..... lack of interest, so it gives an indication of how they deal with relationships.

Interviewer:

So those kind of questions gives you more insight as to how that person is in their relationships?

Participant 3:

Yes absolutely.

Interviewer:

So you said there was a moment you noticed when you asked, can you tell me about that moment of what you perceived in your client.

Participant 3:

I think it was unexpected, then saying that she was taken aback but then she was happy to answer but it did take a moment.

Interviewer:

So there was a pause but then she went on to answer, what was her discomfort like, was there any?

Participant 3:

No not at all I think it just was the initial surprise.

Interviewer:

For you, in relation to things like culture, gender, language differences and age tell me a little bit about those things. Do you think they affect whether you are able to ask questions around sexual history and sexual functioning or not?

Participant 3:

I think it might be quite awkward, if I was dealing with a young girl she might think I'm being a bit judgemental, so that maybe a bit difficult.

Interviewer:

And a person in their mid twenties, thirties?

Participant 3:

It wouldn't be awkward for me, so if it's not awkward for me and I ask it in such a way that it may come across as just part of the questionnaire which I have done before, so if I'm awkward about it that would have an adverse reaction, for example the client even though she was of a similar age to me she felt good because the questionnaire followed structure it became less awkward, I was thinking that she felt let's just continue answering the questions so I think that makes a difference because if it's in a structure. If I had to zone in on it, it would make it more sensitive, I presume, I'm just guessing now.

Interviewer:

And in your mind with culture and gender, what would it be like dealing with people of different culture or gender?

Participant 3:

There again I think the more I keep it as a structured format the less sensitive it is to talk about, so there again I think it just becomes part of the questionnaire so I think if you make it something sensitive then it will become sensitive.

Interviewer:

Do you think that your age makes a difference?

Participant 3:

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I think it definitely does as I've probably been around and seen everything and heard everything especially having children that have gone through different experiences and now are older and having been through their sexual education, I definitely think it does.

Interviewer:

So that also sounds like it has a lot to do with experience, having conversations, because you have not only had conversations with your own children but conversations whilst working at the crisis centre, so this conversation is not a sensitive conversation for you it's a conversation you've been having for years.

Participant 3:

Yes definitely, and because my goal is ultimately to work with offenders I need to be able to talk about really sensitive topics. I have attended courses and workshops on sexual assault and there they almost get you to talk about sex in a different way, they say you cannot work in a sexual assault unit unless you can call things by certain names so you cannot get all silly about it. You have to be able to talk about that. You have to be able to listen to somebody who perhaps has had some really weird experiences.

Interviewer:

So there again it's familiarity with language, familiarity with the topic, the understanding with why it's important? These are the things I'm picking up from you: that it's not this taboo subject any more. However what's interesting is that perhaps for you it's not but for clients it maybe, as you said there was that moment of her not expecting that?

Participant 3:

I think as you become aware of that, I didn't expect that reaction but I think the client realised it was not uncomfortable for me she was able to carry on which is very important.

Interviewer:

Yes because you walked into the room and it was very normal to ask what you were asking, yes very important. So asking around sexual history, sexual functioning, sexuality do you feel it's an invasion of privacy or not? is it part of just gathering a full history? What are your feelings about that being part of the intake.

Participant 3:

I think it's absolutely essential, when I spoke to this particular client, I felt like the total lack of interest and also to do with relationships, I think it's essential and very very important.

Interviewer:

As you said you weren't aware as to where the alliance changed at all after questioning but I think that's the way you broached the subject?

Participant 3:

I don't think it would bother me if it was a male either to be quite honest, because if somebody asked 'why do you need to know that' I would just say: to understand you better. So no it would not bother me.

Interviewer:

And any cultural differences?

Participant 3:

I think what maybe concerns me, which I haven't come across, not cultural differences but more power differences. Perhaps if I had a male that used sex as a means of power I think I might find that difficult, the only reason I would find that difficult is because I worked in the sexual assault unit.

Interviewer:

So it's not the actual topic of sex per say, it's the power and the abuse.

Participant 3:

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Yes I think that's the difference, I'm not talking about in a particular culture, just if there was a power dynamic came into it. Not that it would bother me, I'm just imagining that it could possibly bother me.

Interviewer:

So what strategies would you say you employ to help deal with covering sensitive topics: knowledge, experience, normalising, theoretical?

Participant 3:

I think it's having understanding of what the process is about, of understanding of why you are getting the information. Knowledge and training as well, not in particular sensitive topics. I looked at some of the questions I felt that some were a bit odd, not sensitive questions. So once we did the role-play and got into it, I think you have to be quite fluent in the way you ask the questions. I think if you start stuttering around it so you have to ask it in a way that is quite straight forward, so the moment you actually bring in your awareness of it being a sensitive topic, I think that could be tricky, so I just think you must make sure of the way you questioning it is important.

Interviewer:

And fluency you only really gain from being able to say the words, that you are able to talk about this, it's familiar.

And in your family when you were growing up the topic of sexual health, was that ever discussed, or not?

Participant 3:

Yes it was discussed, it was more in the way of 'let's discuss this book', it wasn't very open it was all a matter of fact. There was one instance reading a newspaper about an incidence of rape and I asked my mother 'what is rape' and she said to me 'where did you get that word from'. I can't remember how she explained it but she wasn't freaked out about it I only remember asking her what it meant.

Interviewer:

So it wasn't really a taboo topic?

Participant 3:

No not at all.

Interviewer:

So your expectations when covering a sensitive topics, it sounds like it was just part of the whole process, there wasn't any huge anxiety around thinking what I've got to do, what I've got to ask?

Participant 3:

No I didn't even think twice about it to be honest. I didn't even look at the question and feel: oh my gosh how am I going to ask this? No it was just part of the questioning, it's just part of functioning, so no not at all.

Interviewer:

Very often it's not seen as part of functioning, it's in a little box that just sits there, so for me my own personal feeling is that's where the issue is, always a taboo.

What do think would have been helpful in training to assist with equipping M1 students? Specifically regarding sex?

Participant 3:

I was thinking maybe to explain why it's necessary? I don't think we actually spoke about that. Perhaps because the people who train us they don't put that part in a box so they may presume that we in fact wouldn't do that. I think perhaps it should be explained as to why we should be doing that, what are the reasons behind asking the questions on sex.

Interviewer:

When you did your role-plays did you ask about sexual history and sexual functioning?

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Participant 3:

No we actually didn't.

Interviewer:

So role- plays are not being utilised to actually practice these words?

Participant 3:

No we didn't. We did alcohol and drugs but not sexual history and sexual functioning. Strange why we did not do that. I wouldn't have had a problem with that, I'm just thinking we might not have had the time to get through all the questions? Perhaps we only chose certain questions as there were so many questions to get through.

Interviewer:

Is there anything else you would like to add or any further thoughts specifically around this topic?

Participant 3:

Just that I feel we should have done role- plays around the topic of sexual health, sexual history and sexual functioning so we can equip ourselves when dealing with clients as to why we ask these sensitive questions.

Participant 4

Interviewer:

My research: what I'm looking at is in our training at M1 level are we trained to deal with taking history regarding sexual history, sexual functioning and basically sexual health? So I am interested in finding out: we have to have this Morrison intake and go through all of it and check it gathering psychological history, so how comfortable do we feel about that part of the interview of talking about sexual history?

Participant 4:

So we're just talking about this?

Interviewer:

Yes and do we understand why we're asking, what's the relevance, what informs you around your own discomfort or levels of ease? So it's basically just a conversation. I've got a few pointers of things that I'll go through but I don't want this to limit any thoughts that you have around the topic. So I'm going to take notes.

Basically if we look at the knowledge of the interview process and content, what was your experience when conducting that first interview with a client, what was that like for you? So not necessarily just about the sexual history side, what was the experience like for you?

Participant 4:

I think most of the first interviews one feels quite anxious about things because it's the first time you're meeting someone and you aren't sure of what to expect. So naturally that experience for me personally was a very rigid one because I had prepared, probably way too much for it. So I was necessarily relaxed with my planning for it, but once it started, because I had a plan and structure that I followed I then eased into it - I could forget about it and let things flow.

Interviewer:

So that structure actually give you some form of comfort?

Participant 4:

Yes.

Interviewer:

When you are talking to your client in that initial first few minutes do you go through the process of orienting the client??

Participant 4:

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Absolutely. So far I've pretty much followed Morrison's, to the tee even to the extent I clock watch - I've done my introductions, I've spoken about confidentiality, I've oriented the person to what we're doing here today. Our roles, and then I feel we've done fifteen minutes so let's move on to the next thing. So I'll say we've covered this and then so let's go to the history taking. I keep the structure in mind but able then to not have to follow it like verbatim but the structure is there with the headings in the back of my mind that I'm following.

Interviewer:

So it sounds that it's very much a comfort and a tool to assist you with how to go forward?

Participant 4:

Absolutely.

Interviewer:

So just for interest do you think that this will always be a way that you would structure first interviews or is this difficult to ask?

Participant 4:

It's a question I've been asking myself quite a bit this last week after attending a marriage workshop, in my mind it's a very dynamic approach, it's very solid, it's a very investigative approach as well, you know what you're going in for. You most likely had a screening down so you have in mind a topic or heading there, other than in this respect I probably would follow the structure. But I hope in the future I won't, maybe follow the main headings where you basically introduce yourself, cover confidentiality and give the person time to talk but I wouldn't necessarily label each section.

Interviewer :

In terms of orienting the client around sensitive topics, how do you approach that?

Participant 4:

I didn't have a specific plan for sensitive topics but I think that for me you can't really prepare for this. Probably better if you don't prepare for it because you're going to handle it in a more real kind of way. I guess my plan just to take it and work with each person, so just thinking of a couple of clients when I've had very easy going or clients that I've had a very good rapport it almost just comes, it doesn't feel awkward or uncomfortable. I can think of a client that it was very difficult and every session was rigid so when it got to that point, because it was one of my first ones, it took me quite a while to do the first intake and also due to the client with her spouse.

Interviewer:

So with sensitive topics like with that client, you had the Morrison form in front of you and it's in the back of your mind. How did you feel knowing that this is a part of history taking that you had to get through specifically with sexual history in mind?

Participant 4:

I think I felt anxious just even thinking about the fact that I'm going to have to do it and I knew with this particular client it was going to be difficult. But then again, I don't know if everyone else does this but I think definitely at that point I hide behind procedures and policies and use that to ease into it. It's really interesting to note that I do that when I've pre-empted some kind of difficulty or some kind of resistance or some kind of guardedness about the topic. If not, if I don't perceive that about my client, it would almost flow in and I would never feel the need to hide behind it. I think that in the back of my mind that if this turns into a difficult situation I'm going to say: this is a necessary question, rather than just having a conversation about it. But just saying that I think of a specific situation where I was interviewing a client and then mentioned something that I was able to use to lead into that. I was so happy inside so I thought this is a fantastic opportunity so let's go in now so I didn't have to have that

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awkward moment of saying: ok now let's talk about this. They almost brought up the topic so I was able to go with the flow.

Interviewer:

So do you think you were adequately prepared for conducting the initial interview with acquiring the general overview of a person's psychological history? Do you think your training adequately prepared you for going through all the areas that you had to ask about?

Participant 4:

I'd say yes it has. It's really that structure because initially you had that long list of absolutely everything that you need to find out about this person in fifteen minutes and it would almost be impossible to do. If you would go through that check list verbatim as if you're almost in hospital you probably won't get through it in an hour or fifty minutes but when you have a conversation about it, it makes it possible.

Interviewer:

So you did find it helpful and the structure gave you comfort as to where you're heading?

Participant 4:

Yes, it's also a base. You know that it's always there so you can deviate when you need to but you always have the security of coming back to it which is nice.

Interviewer:

So there is a familiarity then with the process once you get with your client, understanding the process. So personal challenges around sexual health, your personal challenges, did they help or hinder the process? Or any ideas or feelings towards sexual health and understand why you need to question around that, what things could you draw on that were helpful or what were the things you found difficult to get to talking about sexual history, sexual functioning?

Participant 4:

I suppose whether it was a challenge or not is difficult to say. But what I can say in that regard is that sexual health, sexual orientation and sexuality is something I have purposefully tried to become as informed about it as I can possibly be and a lot of it I probably gained working with Childline so getting that experience, exposure and also socially I suppose exposing myself to people and friends with different sexual orientation, participating in the different drives that they've got and attending workshops and seminars, so you are exposed to it.

Interviewer:

So in other words things don't really shock you that much so you're better prepared?

Participant 4:

Absolutely, so with regard to asking questions about sexual health, sexual orientation all of that it doesn't feel as awkward. In the back of my mind I almost have every possibility that I know about so if somebody does say something I'm not going to react with shock. So it's a preparation but like in an inadvertent way.

Interviewer:

It's not a life skill, it sounds like you've been trying to develop a life skill and understand more about sexual health?

Participant 4:

Yes.... and then that almost prepares you for it, I think the challenge with talking about it is not the actual concept or the act of talking. I think it's the navigating through the murky waters, for some people it may be, because you don't want to shut that person down. You may be happy and comfortable to talk about any topic but you're not sure where they are then you have to almost feel and see where they are and try and go in and talk on a level they are comfortable with.

Interviewer:

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So it sounds like you're saying that it needs to be broached in a way that it's normal? So on that Morrison form there're a whole lot of things you're asking around and sexual health and sexual functioning and sexual history is part of that so you can approach it in a normal way like you would approach everything else? Is that what I've understood what you are saying?

Participant 4:

Absolutely, yes and over this time I think that your research is really interesting and where it's going to play a really important role. I'm not saying to normalise it but to just make sexuality and sexual health, it's something everyone has to deal with, something everyone does. It's still somewhat taboo almost to think about it or even still to talk about it.

Interviewer:

Yes and it does still seem quite a difficult thing for people to get around. So when you introduce your client to sexual health, you say you like to try and ease your way into it. So it doesn't sound like in the back of your mind you think I've got to tick all the boxes, you know that you have to question around that and you wait for an opening to get there? What happens if it doesn't happen? If it's quite a guarded person and the opportunity doesn't arise?

Participant 4:

I've had one specific experience, it became a thing in that session. I know I have to get there, I suppose I probably took the route that most people did and did the whole medical history and figured it in from that approach. So it wasn't more from the interpersonal relationship side of it, it was from more a medical side of it, probably not a good idea to always do that, there should be a good combination of both.

Interviewer:

What was it about that client that made it difficult?

Participant 4:

Culture, religion, I knew it straight away, It was probably bad of me in the beginning, to assume it, I made that assumption, it was an assumption, it was a woman in a patriarchal society. I just could feel it was going to be a wall, so maybe I pre-empted and made that anxiety for myself. I could have possibly created the tension, I was awkward about it but maybe it wouldn't have been. So a lesson learnt not to go in with assumptions.

Interviewer:

What was the assumption?

Participant 4:

The assumption was that this was going to be difficult because this woman is not going to want to talk about her sex life really with her husband. From the beginning I knew he was very controlling and she didn't have much say in her day to day life even in terms of her beauty regime, if that's the right word, and it seemed very controlling. So yes the assumption was that she really doesn't speak about this at all. I think the assumption was that even if she was going to a GP or a gynaecologist it would be very hush, I'm just trying to remember... in the first interview we spoke about the three kids and she didn't speak about being pregnant and her birth and all of that in a relaxed open way. And as a side note, whether it was important or not... I was pregnant at the time so I obviously knew and from a personal experience how you have to talk about those things, think about those things, your body is going through all those things. She almost wormed around them, she was pregnant and had three kids, it just happened, the stork dropped them off and that was it, so the approach to having three kids was that the stork dropped them off.

Interviewer:

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So the assumption is that she probably would not want to talk about that too much, and what was the assumption around religion?

Participant 4:

The assumption with regard to the religion... that it doesn't encourage or allow for that open conversation.

Interviewer:

So being a woman and as you said being in a patriarchal society, added to religion, there's this assumption and quite a normal assumption.

Participant 4:

The assumption was that the religion and cultural practice doesn't allow for that open communication and is something that is kept quiet and behind closed doors, it just happens when people are not around them, I must deal with my assumptions!

Interviewer:

That's very interesting, we all take assumptions into the room, that's why I'm so interested why sometimes it's so easy to talk about it and other times it's not and some people can just question around it and some people can't?

Participant 4:

For sure!!! I think having down that narrative workshop it's so interesting, you're always bringing yourself into it.

Interviewer:

Yes. So for you, do you feel that you understand, it sounds like this life skill you've been working on is a good understanding of why questioning around sexual health is important and relevant. Would that be true? You feel there is relevance around this topic?

Participant 4:

Absolutely, and I think as therapists we should constantly try and improve and develop on those life skills and I think even just now I'm realising that as much as I thought I was doing that. You can still do more of it, you can still prepare yourself more, you can still expose yourself more and learn how to deal with even the difficult or assumed to be difficult situations.

Interviewer:

Well I think sometimes it's interesting because it's like we keep sexual health or sexuality as separate to the rest of a person's functioning. So do we understand that sexual health is part of the complete person?

Participant 4:

I think it should be considered as part of the complete person, because can't say whether this person is depressed but you not going to talk about their sex life or whether this person has got some other situation happening, or if it's a trauma? It's part of life and you need to take that into consideration which includes sexuality and sexual history.

Interviewer:

So if you look back over some of your initial interviews and gathering history can you think of what initiated discomfort, specifically around talking about sexuality, what was perceived? Was it facial expressions? Was it body language? What were those moments that were uncomfortable, for you or the client?

Participant 4:

For me now it was that assumption that I had, cultural and religious that was the one and then with another client it was a completely different scenario where I was working with an adolescent where the adolescent was really used to keeping back information about herself and guarded. And so it was more

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about, not that we were talking about the subject, it was now getting uncomfortable to trust me, it was that trust issue as well which is important, so in order to talk about it you need to trust that person.

Interviewer:

Yes, so then do you think that there is enough rapport built in the first interview to do that or do think talking about sensitive topics is perhaps for later?

Participant 4:

No.....I said no quickly, very quickly [in responding] but I also think it depends on the person and the reason why they're coming and I think this will determine whether the first interview is the right place to do it or not. I think as a therapist you make a judgement call that this is not the right time then the second interview will be the better option it's also something you don't necessarily want to rush into because you want that person to give you honest information you don't want just a generic response.

Interviewer:

So were there moments with your clients that you perceived discomfort or maybe slight reservations in needing to respond to questions around sexual health.

Participant 4:

Working with a client, the adolescent, there definitely was a resistance and guardedness for a couple of the sessions whenever I did bring the topic up I almost knew that the information wasn't real. And that's interesting because in this respect I was constantly bringing the topic up so it was something that was always on my mind because it was pertinent to the case, and I knew that the information wasn't true. So that was also different because the other woman I was resistant.

Interviewer:

So then it's interesting because in an initial interview we have to cover all these topics and that's one of them but it seems to be very linked to rapport and working alliance, so is it always appropriate to do an initial interview?

Participant 4:

I think we get away with it because we just make it clinical and as an individual person you are most like exposed to a doctor and a GP in a very hospital kind of setting, you just ask a whole bunch of questions and you get a whole bunch of answers and the assumption is that the person will give you the truth and the person will give you the right information or the real information, so I think in that way we get away with it. But if you look at it from a therapeutic side and the fact that they're coming for therapy, you're a therapist, you're not a GP or those nurses in an ER doing triage, it's not a triage at all, doing temperatures, blood pressures, I think from a therapeutic perspective rapport is necessary.

Interviewer:

That's interesting because that almost says that in the initial interview you can fall back on that very clinical interview of gathering history and then flag it if maybe it needs to be flagged, was my client resistant about it so perhaps when you move into a more therapeutic level it's something I need to explore when there's more rapport?

Participant 4:

Well what are you really asking [the client]: are you sexual active? Yes or no. I think that those ones you can kind of get your answer and then you can get your history as part of your first intake, but if you're asking deeper more real experiential questions you need rapport.

Interviewer:

That's very very interesting, that's a nice breakdown.

What would you have ascribed to having precipitated some of these little moments of discomfort, so assumptions being one of them, you had an assumption before, is there anything else you can add to that?

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Participant 4:

That led to discomfort either mine or theirs?

Interviewer:

Yes, and adolescent?

Participant 4:

Life stages would follow on the adolescents part because they just naturally keep that side because they not at that stage, they wouldn't talk about it anyway unless they're with their peers so I guess it's building up that rapport to get to that piers level, assumptions is definitely the one.

Interviewer:

Yes we always have assumptions, it's always our assumption as to how the person's going to react when we bring up the topic. Do we make it uncomfortable for our clients, or are they uncomfortable? Is it that we bring it into the room? Or are they already uncomfortable?

Participant 4:

There again I take it back to last year with experience, not once did I feel uncomfortable in a hospital setting and I clearly remember working with a really difficult client at Addington and I went through the entire history in about 40 minutes and it was just cold and clinical and to the point: asking are you sexually active, how many sexual partners, did you use protection? I just ticked the box, move onto the next, whereas if I think about in a clinic in a therapeutic setting that when the hesitance comes in.

Interviewer:

That's really interesting, I like the way you have separated the clinical from the therapeutic. So in relation to culture and gender, language difference and working alliance which of these things do you feel really impact talking around the topic of sexual health?

Participant 4:

For me personally I probably want to say straight away culture and society because I probably personally take the blame of privilege.

Interviewer:

Blaming it to who?

Participant 4:

To culture and society in general and people. I am really generalising at the moment, but people still feel it's taboo even though they say it's not I think there're only a handful of people without even thinking about it will be able to have a conversation about sexuality and sexual health or your own personal sexual experience.

Interviewer:

So you're saying that culture and society make this topic a taboo topic.

Participant 4:

I think in many situations it still dictates how and when a person talks about it.

Interviewer:

Which is interesting because society at large are throwing sex in our face every day, which is so bizarre, it's in our face all the time but no one talks about it. So how does culture affect you, when you have sitting across from you, like me and you, if I'm from a different culture how does affect whether you talk about sexual health or not?

Participant 4:

I think it's probably the same as how you fall back on the clinical perspective, the clinical approach, you can feel comfortable because it's clinical and medical, I think in the same way you would make an assumption based on a person's culture or appearance or their background, what you do know about them, whether they will be comfortable or not, some cultures are comfortable some are not.

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Interviewer:

So what are some of the cultural assumptions you then are talking about, stereo typing, because we all do it, we all have assumptions so what do we base our assumptions on, what would be the assumption on around white people and sexuality? What I'm asking is there a difference in white people and sexuality, black people and sexuality, coloured people, and then breaking it down, is that what we do? Do we have these assumptions pertaining to particular groups?

Participant 4:

TV, linking that to media they throw it in our face quite often, there's a specific age, we hope it's never too young, it's always that right age group, and it's kind of that right group of piers that are sharing in it so in that respect that it's fine to say this if you're between this and this age you openly explore sexuality you can openly talk about it you can play around with it to a degree.

Interviewer:

So you're saying that a person in their sixties there is an assumption that they not as sexual as say the twenty five year olds. So that's what I'm interested in, there are these assumptions that we take in with us?

Participant 4:

Yes I think the whole thing is assumptions, assumptions, assumptions, and I think the media and society almost feed those assumptions. I was just thinking the last time I saw an old couple doing anything more than holding hands, I mean even an old couple holding hands is a big thing: Ah looking that old couple holding holds. You don't often see that but it's not a big thing.

Interviewer:

You've brought up a lot of really interesting things, particularly the age aspect, we assume certain groups of people are and certain groups of people aren't so again when we have client's sitting again we have this in our heads?

Participant 4:

Yes, you are at this age so you are or you not, or you're going to be comfortable talking about it or you're not.

Interviewer:

So how do think these things that we are talking about affect your client's disclosure to you?

Participant 4:

Again I think it's an assumption from their part, they look at you, either a male or a female therapist and are they going to be comfortable based on gender then it's also age comes into play: ok this therapist looks younger than I am or they look older than I am so they're not going to relate because they're too young, they're not going to relate because they're too old or it just so happens that this therapist in front of me, based on their appearance and how they sound so far, they're the kind of person I'll be comfortable with so they're happy to share but I mean how many times are you going to fit that perfect picture for a client. So I think as much as we go in with assumptions a client does as well.

Interviewer:

So I wonder how then questioning around sexual health do we get around the assumptions, is by normalising it?

Participant 4:

Absolutely, it would be it's the only way to go about it actually.

Interviewer:

Because we can't really get beyond our own assumptions as well as what people walk in with?

Participant 4:

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I was just thinking about something so interesting I have to share it with you about my own experience in therapy and then I added a client and my therapist was a much older lady and I think I skirted around the topic. I was pregnant at the time and like what I described about the stork dropping of the baby, I think I did the same thing. I was the client, she was a much older woman, older clearly it wasn't an assumption, there was a level of comfort because she was a woman so there was the feeling that you could relate. I suppose it's whether you can relate or not, I knew from pictures she had grand kids, so she had kids and she had probably been through this before so it almost normalises it in that respect, but then is there a need to discuss it, I don't remember ever in my year of therapy talking about it so again is it necessary, so in your intake do you ask a whole bunch of unnecessary questions.

Interviewer:

Yet we ask suicidal ideation, alcohol abuse medication these are also your sensitive topics, why are we comfortable asking around those things more than asking around sexual health.

Participant 4:

Ok so what's normalised those, is it the risk, I'm asking you know?

Interviewer:

When you were the client did she ask you about alcohol use, medication, suicidal thoughts?

Participant 4:

Yes indirectly it was conversational, because I was also looking at her as a trainee, how was this woman approaching this topic? It was more about engaging in conversation and allowing that free speech in using your skill as a therapist to gather that history without actually asking. So I think that's where the skill lies in getting the information without the person actually being asked point blank.

Interviewer:

But if you reflect back on that, so you recall very subtly questioning around those sensitive topics but did she ask about sexuality, sexual health, sexual history.

Participant 4:

Trying to think back, I don't think she did and it would have been, if you wanted to find a reason to ask about it, when I started seeing her I wasn't pregnant. I then fell pregnant unexpectedly and that obviously impacted my emotional, psychological wellbeing and so it became a part of therapy, that I was pregnant now and I had to deal with all of these things, that would relate to sexual health, you don't get pregnant without having sex.

Interviewer:

So why is it unexpected? Interesting... it's these subtleties I'm interested in, of when is it relevant when is it not why is it easier that we can ask questions around other sensitive topics but not sexuality.

Participant 4:

I'm wondering if as clients you give off a certain energy because it wasn't an issue in terms of sexual history, sexual orientation, so I think that's it, you pick up on those cues, as a married woman I refer to my husband as my 'husband'. If I'm speaking to someone and they speak about my 'partner' I pick up on this, so there again it's about language, language gives away so much.

Interviewer:

So the words you use you already are indicating comfort or discomfort.

So if we get back to the initial interview and asking about a person's sexual history and sexual functioning, do you feel it's an invasion of privacy or as you said it's part of gathering a whole view?

Participant 4:

I think it's part of gathering a whole view and it's always important to have a big picture getting as much information as possible. But I don't think it's necessary to almost bombard a person to exposing themselves so quickly. I'm just thinking, when you first see a person, you're anxious, they're anxious,

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they've obviously got a reason they need to be there which means they've been going through stuff, they've taken a huge step to be there so the last thing you want to do is scare them away, and actually anything can scare them away even if you're not talking about sexual history, and it's just something people general do with friends, family or peers that they are comfortable with so. In terms of normalising it you would have that conversation in an environment or situation we are comfortable with and just don't think the first interview is always comfortable to be able to do that. I think it probably boils down to building that rapport and establishing a therapeutic alliance then it can happen in a real flowing kind of way as opposed to a regimented kind of way.

Interviewer:

The other thing is the relevance, do we understand the relevance of asking , why are we asking that? So a person's sexual health, what does it tell us about them, do we have an understanding about that? Do we have an understanding of why is it important for me to know, so besides the clinical stuff of disease etc, what are the other things that make this line of questioning relevant?

Participant 4:

I don't think we know enough as to why we ask, when we do, I quite honestly don't. I think that's where the relevance comes in and I'm using myself purely as an example. My therapist didn't ask that of me but I had a very fulfilling enriched deep successful therapy sessions with her, as a trainee therapist knowing that I was kind of watching her like a hawk as I had to learn from her and reflecting after each session, her approach towards a client, her technique. There was at no point that feeling she was neglecting me or any part of it and she didn't every have to ask me in a blunt kind of way. It's not that I would have been uncomfortable, if she had have asked me straight away I would have told her and I think that's where it would have ended, it was just a question answer session which is just part of it and it's that question that you think, why? How useful is it, and if we don't think why we're asking it we are not going to use it properly.

Interviewer:

That's what I'm interested in because for me understanding sexual health is understanding things like pleasure giving pleasure receiving being able to connect, body image respect for body of self and other. So that's why it's very difficult to balance, when is it relevant? So why am I asking this? Do I want to get a better understanding of the person's ability to be comfortable, confident and happy, so it seems like there's a gap in being told why we ask this stuff, because it's on the list?

Participant 4:

As therapist we need to have a very good understanding as to why we are asking this, what are we looking for, but then it also falls into the same thing if you know why you're asking it, not because you're avoiding asking it. But maybe sometimes it's nicer to approach it in a less direct kind of way, it's that you can sometimes ask the same kind of questions without actually asking it, understanding why you're asking.

Interviewer:

Yes understanding why you're asking because then you don't fall back on the clinical, of how many times, what age, you gather the history because you understand what you're really looking for. So your personal experience with your client, once you had enquired about sexual health, immediately following that did you perceive that there was a shift in the working alliance or not?

Participant 4:

No not necessarily.

Interviewer:

As you say you were quite able to ask it when you needed to it bring it into the conversation?

Participant 4:

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I would assume, even with my difficult client.

Participant 5

Interviewer:

The research is about: in our M1 year we get taught the whole Morrison Intake. We have to gather this whole psychological history and in that history we have to ask questions around sexual history and sexual functioning. So it's [about] how was that experience for us and do we feel that we were adequately prepared. Was it uncomfortable and did it change the working alliance? This is a semi structured interview so I've got some questions to guide me. Anything you want to add or was interesting or your experience please let me know - this is what I'm trying to understand, what makes it easy for us what makes it difficult for us.

So the first thing is that if we look at the knowledge and the interview process and content - what was your experience when conducting your first interview with a new client? So just in general what was your experience with a new client?

Participant 5:

My first word would be a bit of anxiety. I was anxious because you get this Morrison structure and you feel that you have to stick that structure and you have to collect as much information as possible. So it created that barrier between me and the client because I felt that I had to get as much information as possible. You keep checking that: do I have this, should I ask that? So it really puts you on edge for a first interview.

Interviewer:

Did you go through a process of orienting your client to the therapy process if you did, did it help and if you didn't what did you do?

Participant 5:

Well one of the things I did correctly was orientation. I did orientate my client saying this is what we are going to do today. In a way I felt it put me at ease as well as the client so he knew exactly what we were going to do because sometimes the assumption is they are going to come to the session and we will sort out the problem then and there. But if you orientate them saying this is what we are going to do: gathering information, you then give them the knowledge of what to expect.

Interviewer:

Were you able to orientate around sensitive topics, did you say that we might talk about things that might be difficult or not, or was it a general orientation?

Participant 5:

To be honest it was just a general orientation not specific issues. But there again it might have been because of my anxiety as well. I didn't want to go down that road.

Interviewer:

Tell me about that - you didn't want to go down that road, what road was that?

Participant 5:

When you are going to speak about those sensitive issues it's going to be uncomfortable so I'm not going to talk about this until we get there. I don't want to anticipate that bridge until we get there, it's not the entire session[discussing sexual health].

Interviewer:

Why is that difficult? Why is it an uncomfortable subject?

Participant 5:

Let's talk about sex

One of the sensitive topics, just to go there first, the sexual part and the presenting topic, when I was doing M1 I feared I was not going to be able to contain this person, am I going to be able to help them? Am I going to be able to contain them? And the sexual part is a whole different avenue. The cultural perspective, the gender perspective, all of my clients were female, so being male and asking a female about her sexual functioning would be uncomfortable. And cultural wise they were all black clients as well so it's something that is frowned upon nobody wants to talk about it so that terrain is: don't talk don't tell.

Interviewer:

So in the initial interview when you know you have to go through all this stuff is this in the back of your mind that you are now going to have to ask these questions?

Participant 5:

Yes I think it is in the back of your mind, it just makes you feel a bit anxious. I would try if that question was asked.

Interviewer:

So if you could avoid it you would?

Participant 5:

Definitely I would, personally I would feel uncomfortable especially older clients - it just makes it difficult.

Interviewer:

So do you think you were adequately prepared for the process of conducting this initial interview with acquiring a whole overview of a person's psychological functioning?

Participant 5:

I think we were prepared. When it comes to the sexual history that is the main portion that I felt wasn't really targeted. I wasn't really happy with that. For example from my side the gender the culture, the age - so looking at that I feel I wasn't adequately prepared.

Interviewer:

The general process you felt you were adequately prepared for just not really around gathering sexual history sexual functioning?

Participant 5:

General process I was prepared but that section... no.

Interviewer:

So for you there was a familiarity with the process, you understood what the process was and you understood why you had to ask all these questions?

Participant 5:

Yes, I felt I had to ask these questions. On some aspects I didn't really know how these questions would relate but never the less I had to ask them.

Interviewer :

So you didn't know the relevance?

Participant 5:

Some sections had relevance, some sections didn't have much bearing on what we were discussing.

Interviewer:

So for you personally, your own challenges, your thoughts around sexuality, sexual health, sexual functioning - do think that hindered or assisted in the process? Your own personal feelings about it?

Participant 5:

Let's talk about sex

I would say for the clients I saw it didn't assist in the process at all because there was discomfort on both sides. From my side and the clients' side as well and again it felt like there was not much relevance. So I wouldn't say it hindered but it didn't really assist in the process as a whole.

Interviewer:

If you did and perhaps with subsequent clients, how did you introduce your client to the topic?

Participant 5:

That's a difficult one because I think I never really introduced them to the topic I just went straight to the question.

Interviewer:

You're not alone in this by the way, it's a very common response.

Participant 5:

I didn't really know how to introduce the topic and why I was introducing the topic. It felt much easier just to ask.

Interviewer:

Ok, then what did you ask?

Participant 5:

Your first sexual experience - which I felt was intrusive. How many partners, your sexual functions - the clients felt uncomfortable. I felt bad at that moment. It's really hard for me, I skip the question.

Interviewer:

That's interesting. Your responses are pretty much was everyone is saying [all the participants].

So do we adequately understand the importance of information around sexuality?

Participant 5:

I think not entirely. If you're asking about sexual functioning ... In my intake I don't go back to that - asking about sexual experiences. I don't know what I'm going to do with that, what information do I need and what am I going to do with that? Why am I asking you that? What bearing does it have on the intake?

Interviewer:

Would it be useful to your client if you say: the reason why I'm asking you this is that it gives me an indication about how you ... Does that make it easier?

Participant 5:

It certainly makes it easier for me, the first step is to know why I'm asking this.

Interviewer:

Like why do we ask around suicide? We need to have an understanding as why is it on the list, why are we asking this?

So can you describe then the moments that initiated any discomforts in you or in your client when you had to start asking anything around sexuality?

Participant 5:

For me it was a problem I finally had to ask: do you feel like having sex? I immediately felt what did you ask that for? I'm a male you're a female so do you feel like having sex? For me this was not the right way to ask. For me I have not found the correct way to ask about that especially about the sexual functioning, the number of sexual partners...

Interviewer:

What is your concern about your client? What are you concerned about? What they are going to think or feel?

Participant 5:

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If you think of it from a cultural perspective and the clients we see, there are cultural intricacies. If you're seeing a black guy there a lot of things on sexual stuff so how are they going to interpret all this stuff? How comfortable are they? Most people are not really open for that and being a male asking a female it just makes it uncomfortable.

Interviewer:

So it would be easier to talk to a male?

Participant 5:

The males I have spoken to it has been easier, there are factors involved. For instance age - age is a critical factor.

Interviewer:

Your discomfort, how did you perceive that? Did you feel anxious, did you rush through it? Did you ignore it, avoid it?

Participant 5:

I think that I just breeze through it I never dwell on a question and move on to the next question.

Interviewer:

And in your client, when you've brought this topic up what do you perceive in your client that there is discomfort there, is it facial expression, what do you pick up from you clients?

Participant 5:

I think facial expression and response time. They don't respond as with other questions - they pause, and it's like, why are you asking me that question?

Interviewer:

So when you see that you think: ok back off a bit?

So in relation to the effects of culture, you've mentioned this before, culture, gender and language differences and working alliance and disclosure how are they present in the room?

Participant 5:

They are very prominent especially when you speak about language, when you're working with a client that can speak English very well it becomes a less anxious process to speak about sexual functioning. If you speaking to a client that speaks Zulu it becomes a really different process.

Interviewer:

Tell me about that.

Participant 5:

The words...you can't find the right words to ask about sexual performance.

Interviewer:

Why is that?

Participant 5:

Because the words we have in a way are very direct there's no sugar coating. So using English is much better, using Zulu words will be quite difficult.

Interviewer:

Gender? You said you feel that gender it is also more difficult speaking to a female client?

Participant 5:

Yes I find it more difficult. I have my own anxiety and they have their own anxiety. In all cultures even speaking to a male about sexual things is anxiety invoking.

Interviewer:

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Again what is your concern when talking to a female client about sex, what is the discomfort there? I'm interested in what's deeper there? Why is it easier to speak to a person of the same gender, what is it that makes it difficult?

Participant 5:

Well I think when you look at it, it shouldn't be difficult but for me I can relate to a male there is less discomfort. I think it's just cross gender followed by society but it shouldn't. There are things that you shouldn't discuss with females and things you can discuss with males.

Interviewer:

And do you think that is quite tied to culture as well?

Participant 5:

I think so in most conservative cultures the whole sexual matter is not spoken about. It's something you don't speak about at home, you just don't talk about it so it becomes a huge difficulty to talk about this to a stranger. So in my social circles I am taught not to speak about it and my client also is taught not to speak about it socially. So it's two different people who socialise in the same way not to speak about that, they are now forced to speak about that, so when it comes to asking the question we are at a bit of a loss.

Interviewer:

So in your own home was sex not discussed.

Participant 5:

OMG no never, absolutely not there is no discussion around that. No one talks about that even with your older brothers and older sister there is just no discussion.

Interviewer:

So how did you find out about sex?

Participant 5:

Through kids and friends at school, primary school, high school, kids talk, even at school nobody would speak about sex. At high school I had a very liberal teacher so she introduced sex but all the other teachers, no. I come from a very small conservative Christian background so sexual things are not discussed.

Interviewer:

So then do you think religion also plays a part in this?

Participant 5:

Absolutely! I think the discomfort there, being a Christian myself, I have my own convictions around sex and sexual intimacy so when you look at discussing issues with a person who's married and having sexual intercourse, it becomes difficult because you have your own judgement about premarital sex or marital sex, so you have all this discomfort in yourself as well.

Interviewer:

So religion is also in the room?

Participant 5:

Yes, so for me religion is a huge factor, I see myself as a devout Christian. I have confidence within myself, so I wish I would like to deal with it but they come with their own issues.

Interviewer:

So the conflict is specifically around sex? So that's your own conflict and things that you are working on, and now you have to ask this and don't really have a good understanding of why I'm asking this? So a lot of anxiety just in that, and then you've got culture and gender and age.

Participant 5:

Absolutely!

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Interviewer:

Tell me about age.

Participant 5:

If I see a 24 or 25 year old male it will be very much easier to discuss this, we are more or less the same age we do the same things we share the same preferences mostly. But if I see a 78 year old this is a problem. When you see this client, asking them about sexual intercourse, again culture and age, they say I don't have sexual dysfunction, and I don't do sex [because of age].

Interviewer:

How do you know a 78 year old is not having sex?

Participant 5:

Yes this is very true because we have a huge belief when you get older sex is something you don't have any more, it shouldn't happen, older people shouldn't have sex, even if they're married, it's nasty.

Interviewer:

This is very interesting. This is what we bring into the room.

Participant 5:

In our community you see these older couples but you never think they are engaging in sex, only for young married couples not for old people.

Interviewer:

So when you're older sex is not appropriate? What about when you're young, not young in your twenties, younger.

Participant 5:

When you're young you shouldn't have that, when you're older you shouldn't have that. So there are only a few years you can enjoy sex. When you look at the younger generation this is where religion comes in, not so much culture because in this modern age culture does not play a huge role, so you can't have premarital sex it's wrong - it's a sin only young people that are married should have sex.

Interviewer:

If you had an adolescent client, how do you deal with this topic with a 15 or 16 year old ?

Participant 5:

There again I have my own convictions of saying you shouldn't be having sex. You ask the questions but at the back of your mind you have your own judgements: you shouldn't be having sex, you're too young, it really becomes an uncomfortable topic. Even with married couples it is uncomfortable - you have your own judgements.

Interviewer:

So if you have an adolescent client are you able to ask them that? What is the level of discomfort for you in comparison to a 78 year old to now say a 16 year old?

Participant 5:

I think it was more comfortable to have this power over a younger client. For the older client it's like ok you're not a child so they have more power but if you're dealing with a young child you have more power over them. I can ask this any way I like so with a child you have more power.

Interviewer:

So do you think then, your client's ability to disclose, do you think it's an invasion of privacy? Their presenting reason for coming to therapy, do you think that plays a part if you had to ask your client about sexual history, sexual functioning?

Participant 5:

I think how I feel, in a way it's an invasion of privacy, personally I wouldn't feel comfortable in being asked about sexual things. But if it's directly related to that, if a person is coming in because of sexual

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dysfunctioning then I become anxious but if it is not really tied to the presenting problem... this is not why I am here. So depending on the presenting problem determines the anxiety levels in asking around those questions.

Interviewer:

So were you aware at all with the working alliance being affected or was it a concern of yours when asking around sexual health, sexual history and sexual functioning?

Participant 5:

I think it was a concern because for me it was a bit of a break when you ask that. It's breaking the communication which I found it was better in subsequent sessions marking that so just asking that then and forgetting that I asked that and never going back to that again. It becomes a forgotten rupture, so to say.

Interviewer:

Ok, it's difficult because we have to ask this question in an intake where we have only just met this person. So do you think it's easier, should there be a working alliance and good rapport to be able to ask these kind of questions or do you think it's easier to do it in the beginning?

Participant 5:

Certainly, there has to be a good rapport because it affects their ability to answer. Their number of partners they have had in the past- it's quite embarrassing. It could be 10 partners so it labels you as this loose person and if I had to disclose this to you I stand the chance of being judged. So I think a good working relationship, trust, comfort is essential.

Interviewer:

That's interesting- judgement. Is judgement tied to the question around sex?

Participant 5:

I think the response from the client as well there is that thing about judgement. Everyone feels judgement whether I'm 10 years old or 60 years old. So it would be easier to say I only had sex when I got married so there wouldn't be any judgement but if I was younger I stand a chance of being judged. A good rapport in a critical relationship will make way for an honest answer because a person will be at ease and feels: I won't be judged by whatever I say to you. But initially the client is still testing the waters: should I trust this person. You're really disclosing all these sexual matters which is a hugely sensitive topic.

Interviewer:

So tell me then, talking about sensitive topics- how were you talking around suicide, alcohol abuse, drug use? Were you able to ask around those sensitive topics?

Participant 5:

With those sensitive topics I was able to ask about them. I didn't feel so anxious. Drugs are a social problem, alcohol and smoking doesn't have much stigma but when it comes to using drugs it becomes uncomfortable because you have your own prejudices and society says using drugs is not a good thing, it's a forbidden thing. So that section with drug use itself, maybe it shouldn't be anxiety provoking but your own conviction and beliefs of what is right and wrong makes you feel anxious about asking these questions.

Interviewer:

If we had to put sex, drug use, alcohol use, over counter medicine, suicidality, if we had to put all those next to each other which would you say on a ranking scale, which is the easiest one to deal with and which is the most difficult one to deal with?

Participant 5:

Let's talk about sex

I think suicide and over the counter medication and drugs, it was easy for me to deal with. Sex was the problem.

Interviewer:

Why? Because if you think about it, talking about suicidal ideation, that's also quite a personal intimate thing to ask somebody about: do you think about killing yourself? So why is there not a problem asking about that but there's a problem asking about sex?

Participant 5:

Really intimate things are on different levels- when it comes to sex for me it brings a whole different story. It relates to your body and everything around that while suicide... again it's a sensitive topic, I don't know, for me it's my own beliefs around that.

Interviewer:

I was just thinking, we have workshops on suicide. I was always quite anxious about suicide but after doing the workshops I understood why I was asking and what I was looking for. So do you think it normalised it and made it easier to ask around? Whereas sex, maybe there wasn't that much information given?

Participant 5:

I know you get more information on that topic so it puts you more at ease so I think the workshops really helped to understand suicide and for me it's understanding it creates that empathy - it's easy for you to ask that because you have that connection with that person, understanding why we are asking about suicide but sex....

Interviewer:

It's quite tricky asking about suicide: why you're wanting to take your own life. But you can do that in preference to asking around sex health and sexual functioning?

Participant 5:

Yes, but a person coming in to talk about suicide and discussing it, it normalises the topic and then I become more at ease. But sex... they didn't come specifically to talk about it.

Interviewer:

So it didn't normalise it?

Participant 5:

No.

Interviewer:

Yet we had to ask it.

Participant 5:

Unfortunately.

Interviewer:

So what were your expectations about covering sensitive topics in the first interview? When you went into the first interview what were expectations about covering sensitive topics specifically sex?

Participant 5:

I didn't have much expectation, I didn't know how to ask it.

Interviewer:

Did you just ignore it, did you just hope it would go away?

Participant 5:

I just asked, I just rushed through it, without probing. I never really probed.

Interviewer:

Now of interest.. how would you feel if someone came in specifically with a sexual dysfunction? How would you cope with that client if that was their referral was.

Let's talk about sex

Participant 5:

I had two clients with that problem, they were both female I think the first thing that I initially had a problem with was the gender. I had to ask them if they felt comfortable, so they said they were comfortable so it opened the doors. So when you're discussing the sexual parts it becomes less anxious, so when you present that question they know that they are going to discuss that.

Interviewer:

So what would you do differently when approaching the topic of sexual health with your intake?

Participant 5:

I ask myself that question every day. I haven't really found a way of approaching that so I skip that part with my oldest clients. I literally lose confidence, specifically an older English lady or an old black lady, how do you ask about your sexual experience?

Interviewer:

So there again where is the relevance and what are you trying to understand?

Participant 5:

Even more to that, it scares the hell out of me...that question. I have been able to ask younger people, say even forty but when it comes to really older it is more difficult, I really have found a way to do it or to alleviate my own anxiety.

Interviewer:

So what do you think would have been helpful in your training to equip you with dealing with sensitive topics around sexual functioning and sexual health?

Participant 5:

I think the workshops are obvious not just sexual functioning but looking at the different cultures, looking at the different ages, looking at the different genders taking those, if you look at the South African population... usually female, Indian, black people, looking at culture and the ages, I have had white clients, so it's not really the culture per say it's more the age.

Interviewer:

So you think age is more of a problem than culture?

Participant 5:

Yes I think if you look at all the clients that come in, age is more of a problem.

Interviewer:

Age and gender?

Participant 5:

Yes age and gender, the majority of clients are female.

Interviewer:

So you are constantly confronted with the same problem? Just for interest, how were your role- plays did you practice talking about sex?

Participant 5:

No. No never.

Interviewer:

So in your role-play you went through all this and you avoided sex?

Participant 6

Interviewer:

Generally what was your experience when conducting that first interview?

Participant 6:

Let's talk about sex

Initially that there is too much and you do not want to be sitting staring at this piece of paper and reading off of it. But as time goes by and you start to learn what types of questions you need to ask it's not so daunting but initially it was, and I think a lot of the questions. Even though you ask them initially you actually don't get the proper answer until sessions later or right at the end of the session although you may have asked a question earlier it only emerges later. So yes that's a bit odd, I don't know if it's the way the questions are asked.

Interviewer:

You've got a schedule really that you have to go through so is it a sense of: I just have to get through it without any deeper understanding?

Participant 6:

Yes definitely - you seem to get stuck on just ticking boxes than rather engaging in a conversation. So it limits the flow a lot and you miss a lot and I notice from watching my first interview when I would ask a question, I would be told something quite important by the client but I didn't pick up on it because I was preoccupied with what the questions should be next and I missed the opportunity to go into what was important.

Interviewer:

So then if you look specifically at the sensitive topics, when you went in knowing that this was part of the intake what was your experience with feelings around that part of the interview?

Participant 6:

A lot of anxiety with regard to the fact that you don't know the person so it was very uncomfortable for me to ask sensitive questions around sexual history or suicide as well and trying to word it in a soft manner without actually losing what you're trying to ask. Which I actually did lose what I was trying to ask.

Interviewer:

Because of the discomfort and anxiety around it?

Participant 6:

Yes.

Interviewer:

So do you think you were adequately prepared for that initial interview with your first client?

Participant 6:

It's tough to say because we did have role-plays and those helped a lot, they really did. But in terms of being prepared I think even with those role plays we still weren't prepared enough because at the end of the day you know they're role-plays and not a real encounter and you're not as anxious and nervous as when you first see your very first client. So yes it did in a sense but no even if they had done more I don't think it would have made it any better you just need to go in there and learn through experience.

Interviewer:

Just for interest sake, in your role-plays in your group, did you actually practice asking sensitive topics, specifically sexual history, sexual functioning?

Participant 6:

It was one of our seminar topics where we practiced asking about it but I don't think we really did it properly, because in our group we just focused on the wording aspect but not dealing with anything else, but purely of how we would say it, in terms of words we would use.

Interviewer:

What was the discussion around that?

Participant 6:

It was around asking it but in a soft manner.

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Interviewer:

So what words would feel comfortable?

Participant 6:

I actually can't remember, but I know we sat with it. So when we saw words like sexual history we would ask questions around puberty for example, which people don't necessarily link that up but because it was uncomfortable for us it was easier to ask about puberty than actual sexual history as such.

Interviewer:

With your sensitive topics I know you also said suicide was also uncomfortable to question around? But was that also as uncomfortable as asking around sexual functioning and sexual history? Which was the most difficult?

Participant 6:

I think the sexual history.

Interviewer:

More so than even asking around suicidal ideation?

Participant 6:

Yes because that is very personal and I think they kind of expect on some level that you will ask them about suicide but the sexual history was more uncomfortable.

Interviewer:

Why is it to ask around suicidal ideation is it not personal as asking around sexual functioning?

Participant 6:

I don't know really. We were actually having this discussion at the hospital because it came about that someone was asking why is it that some of the psychotic patients have sexual fantasies or hallucinations and I think the sexuality in general is a very sensitive topic. I mean on any level even in body changes when you're younger, in terms of your preference, everything about it is uncomfortable. So I think as much as you would like to feel comfortable it's just one of those strange things but that broad topic it just is uncomfortable.

Interviewer:

That's what I'm interested in. Why is it such a difficult construct to talk about, for a client as well as for a clinician? So you have a familiarity with the process of what's expected of you in the initial interview and hovering in the back of your mind is the thought that: I have to get to these sensitive topics, specifically sexual functioning. On a personal level what are your ideas that hinge around sexual history, sexuality, did it make it easy for you to talk about or difficult to talk about?

Participant 6:

It definitely makes it difficult. It's never been an open topic and this is largely because of religion, my mother was always open but there was always the sense that although she was always open you just don't talk about it. So that's why for me it is always uncomfortable because it was not something I was used to talking about openly.

Interviewer:

It's not a familiar conversation?

Participant 6:

No. I don't think my parents ever gave me the 'sex talk', and if they did I can't remember, it might not have been directly to the point or not done at all. So I think that I missed that aspect. It's difficult for me to now bring that topic up because I have nothing to draw on.

Interviewer:

So where did you learn about sex? If not from your parents.

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Participant 6:

School.

Interviewer:

School and peers, it definitely seems to be the case, do you remember what age you were?

Participant 6:

No, really not sure.

Interviewer:

That's fine, I just was interested. Do you think what you learnt through your peers, do you think it was correct biologically or was it a bit unclear? You were not sure - did you clarify the information you got from your peers?

Participant 6:

I think at an early level it's definitely unclear and everyone makes up their own assumptions at that stage. I think it only becomes clear when you start defining it for yourself, start learning for yourself and then making those connections.

Interviewer:

So it never seems to be an open conversation in the home?

Participant 6:

Strangely enough I have a sister who is eight years younger than me, she recognises that it is less uncomfortable for me than the rest of my family. Her and I talk about it a lot but more in a joking manner than a serious manner. So even with me knowing more and being more comfortable than I was before it still is with my sister quite uncomfortable to have a conversation about it.

Interviewer:

So in the initial intake interview do you orientate your client to the process of therapy: this is what's going to happen, this is what this first interview is all about... do you do that?

Participant 6:

Yes.

Interviewer:

Do you orientate them around sensitive topics?

Participant 6:

No. In a role-play I did actually say I will be asking you some questions. But with a real client I didn't want to alert them to the fact that it was sensitive because it makes it more difficult for me to ask. So no I didn't.

Interviewer:

So do you understand why you need to ask around sexual functioning and sexual history?

Participant 6:

Yes I do. Sexual functioning: one reason why is sometimes it's diagnostic, and sexual history - it is also quite important to understand whether there was any abuse, how early did they initiate any sexual activity. Yes I think that's very important to get that information, however I don't think it's useful in the intake. As I said neither party knows each other, they are less likely to be honest particularly if they pick up that I'm anxious about asking about it.

Interviewer:

But do you think that if your own anxiety was not in the room do you think that would make it easier?

Participant 6:

A little bit but not so much, because it's one of those sensitive topics that don't get discussed, even if I was less anxious about it I still don't think so.

Interviewer:

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So you think there should be more rapport?

Participant 6:

Yes I do, unless you're dealing with someone who is a lot older and is comfortable with discussing it. If not I think it needs to be done later, it's not a crucial thing unless they're being sexually abused.

Interviewer:

So you just commented now that if a person is older, do you feel that they would be more at ease talking about that.

Participant 6:

I think so, I think because they come to terms [with sexual health through experience] by themselves and they are more comfortable with their own sexuality to some degree. But more so with talking about it. It's normalised because they're older. But I think when you're younger like my one client is younger, he's a male and I'm a female, it was very uncomfortable for him to answer. He just chuckled saying: no, no, no, - which one would expect because he was only fourteen but still there's that thing that if you're younger and you haven't quite accepted it, it is very difficult.

Interviewer:

It's almost like there is a societal expectation as well? We have an assumption... well I'm going on my own assumptions, that perhaps older people have sex so they more comfortable about it but younger people are not supposed to be having sex so there's this expectation. Who is allowed to talk about it and who is not?

So you were just saying now you had a fourteen year old client and you were able to ask around sexual history and sexual functioning?

Participant 6:

Yes but in a very uncomfortable way, the reason why it was uncomfortable it was not because of asking about sex itself but because I didn't want to plant the idea if it wasn't there. So I was very hesitant about bringing it up and how much does he know and he seemed to know about it and brushed it off. But verses my eleven year old client that I had it was even more difficult because he was Muslim and I especially did not want to ask anything that was inappropriate so I had started with life orientation about the body image. He didn't know anything about that, he doesn't do life orientation at school so I thought ok I'm not bringing it up because with him being Muslim I don't want to cause something that would be uncomfortable for him.

Interviewer:

So as you said because for you religion has played quite a big part in your belief system around sex and sexuality?

Participant 6:

Yes and with regard to talking about it.

Interviewer:

So immediately you know he's from another religious group, so what's the thinking around that?

Participant 6:

It's more likely that he hasn't spoken about it and the assumption that he hasn't engaged in any sexual activity, which I know is not the correct assumption to make. But like I said I was very hesitant, and his family was very staunch and I did not want them to come back to me saying why did I ask these questions and put these ideas into his head.

Interviewer:

So describe the moment that initiated that feeling of discomfort with your fourteen year old.

Participant 6:

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I asked him if he was aware of sex and does he learn about it at school, he said yes. I asked him if he was sexually active, he didn't answer me. I asked if he learned life orientation at school, so he said: yes, yes I know all of that stuff - and brushed it off. I was not comfortable to stay there so I quickly jumped onto the next topic, which was quite a bad thing because there's potentially sexual abuse in him that I didn't pick up because I rushed through it.

Interviewer:

Having rushed through it you could put a tick on the piece of paper?

Participant 6:

Exactly and also defining what they mean by it? What part of sexual history? Knowing exactly what to question.

Interviewer:

So there almost needs to be a deeper understanding of: why am I asking this? What am I actually looking for? So this is also what I'm interested in. Do we understand what information we're trying to extract or is it just another thing on a piece of paper that we're trying to get through?

Participant 6:

I think initially you're still very new and you haven't had many client exposures and contacts, it is about a sense of just getting through the interview. But I think as you start to get more comfortable you start to realise the significance of it and now I'm less uncomfortable and anxious and I find it quite easy to ask my clients, but again within reason as to whom my client is.

Interviewer:

So tell me about that, what are the things for you when in the room it makes it more difficult? Gender, culture, religion, tell me a bit more about those things.

Participant 6:

The one is age, as I mentioned. So if it's a younger client it's more uncomfortable - I do not want to plant the idea. Religion also makes it uncomfortable, but once I know what their religious affiliation is, I make an assumption as to what is appropriate to ask. Gender - I can't talk about adult males because I haven't had an adult client to know practically how it's going to feel but both male clients I have had have been adolescent and pre-adolescent and that was difficult. But I don't think it was the gender, it was more the age.

Interviewer:

So if it had have been an eleven year old and fourteen year old girl it would have been uncomfortable, more the age of putting ideas into the head?

Participant 6:

Yes. I think it makes it easier knowing that they have had sexual encounters. I feel more comfortable. So the assumption is that it is not uncomfortable for them to talk about it because they have had a sexual experience.

Interviewer:

Culture, does that play a part at all?

Participant 6:

I suppose it would in the sense of being an Indian, actually I think Indian to be honest.

Interviewer:

Why what would the thinking behind that be?

Participant 6:

Again I think it would be tied to the religion and the culture.

Interviewer:

Are we talking Muslim? Hindu?

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Participant 6:

I think mainly Muslim, to me Muslim's seem to be a lot more staunch.

Interviewer:

This is what I'm interested in because we take assumptions into the room, I am really fascinated by it.

Participant 6:

I think with Muslim's, they are just more forceful, if you look at any supermarkets you see halaal meats dominating. They are very forceful as a religious group that's why the assumption that they're more staunch. I know a lot of Muslim - there are a lot of dynamics. The male is always in control and there's no breaking the rules or going outside of your religion. Very strict, a lot of Christian religions are a lot more flexible.

Interviewer:

And in relation to sex, again an assumption, as in sex being Muslim and sex being Christian, what is the difference?

Participant 6:

Well again it's the flexibility, I think with Christians it's not that clearly defined as with Muslims, Christianity there are a lot of people that are Christians have sexual encounters, sex before marriage. It's quite acceptable, but with Muslims it is not acceptable to have different sexual encounters, pre-marital sex.

Interviewer:

Again this is an assumption - we all bring assumptions into the room. But again age is your biggest cause of discomfort and gauge whether you would stay with the topic or not? So how does it feel say a male the same age as you, being twenty six, to discuss sexual history?

Participant 6:

Not uncomfortable at all.

Interviewer:

So these things: age, culture, gender and religion - do you think they also come into the room with assumptions, sitting with you the clinician, they would be able to disclose or not disclose?

Participant 6:

Definitely. I think this is related in a sense. It's not directly answering your question - when I asked the one client what was their religion they almost got the sense that can I religiously counsel them because his response was 'no I'm not religious'. I'm a Christian but I'm not a practising Christian so you can counsel me however you want to counsel me so I think they also make assumptions as to what your religion is and how you view the topic as well.

Interviewer:

And also assumptions, I would think? On how they view you as a female, twenty six year old white? So those things also come into the room and how your clients perceive you and are they comfortable to disclose certain things.

Participant 6:

Exactly, I had a forty nine year old male who didn't disclose anything, and then I had his partner who was in her mid-fifties and she found it very comfortable to discuss every detail and every aspect. But for him it was uncomfortable.

Interviewer:

So you did an initial intake with him?

Participant 6:

Yes.

Interviewer:

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Did you get to sexual history and sexual functioning?

Participant 6:

I did but with him it wasn't about him directly which was strange. It was getting an intake with regard to his son. So with him even discussing in terms of his son's sexual history, he said his partner knows about that he doesn't talk to his son about that. But when I spoke to his partner she spoke about it in terms of her own experience with him and her dissatisfaction in her sexual relationship, so she was very open and he, although it was not about him and I think part of that was I was a twenty six year old trainee who doesn't really know what I'm talking about. So he did not want to talk about anything too personal.

Interviewer:

Very interesting, so I wonder what was in the room that day? Was it age or was it gender? I wonder if you had been thirty and qualified if he would have been able to talk about anything to do with sexuality, or not because if he can't speak to his son about it

Participant 6:

I think for him it was largely gender because he is quite sexist. I think even if I was the same age as him and female. The feeling I got from him he talks down to women. He does not have good things to say when he describes women so I think for him it was that. But for me it was very uncomfortable because he was the same age as my dad and for me it was as if I was asking my dad so it made it incredibly more uncomfortable for me.

Interviewer:

So again age is now an issue on the other side of the spectrum, what is the assumption there? You being younger and this man being older?

Participant 6:

It relates to the whole thing as seeing him as the same classification as my dad. I wouldn't just go to my dad and start asking him about his sexual history or anything like that, and it's never been something that him and I have ever spoken about. I don't know how to initiate a conversation with a man in his late forties, fifties because I have nothing to draw on.

Interviewer:

There's been no practice but why can you discuss everything else? We can discuss a person's drug use, a person's alcohol use and whether they think about killing themselves, because those are all intimate personal things about a person. Yet this topic is seriously off limits?

Participant 6:

I think for both parties. I think the men if they're going to a psychologist there is an expectation that they are going to have to talk about suicide ideation, there is a linkage between sexual history and sexuality and mental health in the common individuals mind. So I think they're comfortable to answer questions, they expect to discuss suicide but I don't think they make the link between sexual topics and mental health.

Interviewer:

Yet the interesting thing is that most of us are in relationships. We are expected to be happy in our relationships. There's the assumption we're having sex if we're in a relationship, so a lot of our lives are involved with sex and sexuality but that topic is never discussed which is so fascinating for me.

Participant 6:

I suppose that's why Freud was so popular. It is one of those strange topics that don't get discussed.

Interviewer:

We have babies, we have people in therapy that we know have either made babies, because they're a man or they've given birth to babies so we know that this is happening all the time but it's just a completely taboo subject. So what would you say are some of the reasons that assist or hinder you in

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questioning around this, are you hesitant to ask because it's an invasion of privacy? Not having things to draw on?

Participant 6:

I think what hinders me from my perspective of what would make me comfortable and I think I only feel comfortable to talk about sexual things, I'm talking about people I know not clients. When I know that person when we have a relationship, a friendship or any other kind of relationship that has been established. So when I draw on my personal experience I would tell someone. I wouldn't tell someone initially because you don't know how they are going to react. You don't know what sort of judgements are going to come along with that so that's always what hinders me so that's why I make the assumption that it's going to hinder others as well and that's why I feel it needs to be done when there's more rapport. It's partly because of that I would not be completely honest with someone that I had just met.

Interviewer:

So it's like a very fine balance between: we need to know this information but we also don't want to make our client uncomfortable? Does it help to orientate your client better? Do we need to normalise it for ourselves and how relevant and important for us to ask? So what would assist you in questioning around sexual history and sexual functioning?

Participant 6:

I can't say anything other than loads of exposure and experience. I don't even think if you had seminar upon seminar of practising it, again it's for a forced situation.

Interviewer:

So if we look at the working alliance then and you think back on your clients now what were the aspects or moments that you were aware of having an effect on the working alliance? Do you think that when you asked around sexual history and sexual functioning did you feel there was a rupture in the working alliance at all?

Participant 6:

No, because I don't think one was established.

Interviewer:

Yes you try and build a rapport with a person and you're getting on really nicely and now you're back at asking about their sexual history. So then how could it possibly affect the working alliance, so it's quite tricky?

Participant 6:

I think I do need to bring it up with one of my clients and I have tried on numerous sessions because his dad did say that possibly when he was two or somewhere around there, there's rumour that when he was living with his mom there was sexual abuse. I tried bringing it up with him and again it didn't go well because I was not direct and to the point and I had asked him if anyone had violated him in any way, physically. Any way ... and I don't think he understood what I meant and again it goes back to implanting and it was my thoughts that if he was two he doesn't even remember it. So now I don't want to introduce something that is critical for me to understand but could possibly be a huge source of distress for him.

Interviewer:

So what are the skills you used to create a good rapport with your client, is the preparation, is it the process?

Participant 6:

It's preparation in the sense of what type of questions to ask because I've noticed that it's much more helpful to build rapport with your piece of paper over on the desk, because right at the beginning of the interview I was too focused on writing and so I lost it. So I think rapport gets built when they know

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you're actually listening and you know what they're saying to you and huge amounts of empathy no matter what they tell you.

Interviewer:

Is there any way you can use those skills you've mentioned like building rapport through conversation and huge amounts of empathy that you could use when dealing with sexual history and sexual functioning? Because this sounds like you're having a normal conversation so could you not have a normal conversation around sexual history.

Participant 6:

I think it is possible but for me it still will largely be determined by who I'm talking to. So I think that it will be something I will take a long time to get over.

Interviewer:

Once you had enquired around sexual health, how did you perceive your rapport immediately afterward? There obviously wasn't a major working alliance yet but how did you perceive in the moments after that, the rapport between the two of you?

Participant 6:

I didn't notice anything again because I didn't ask it direct enough so there wasn't really an impact on the outcome except for creating a little bit of discomfort in the room and then quickly moving on.

Interviewer:

So it's easy then to dissipate that discomfort by just changing the topic, you quickly move on and it goes out the room?

Participant 6:

Yes, you sort of lock it away.

Interviewer:

Do you think it would assist you as well as the client to frame the topic of sexual health?

Participant 6:

I think so. I think it would be helpful if a bit of psycho education went along with it in making the link so that it doesn't seem as if you're violating unnecessarily. Helping them to make the link between sexual health and sexual functioning and mental health. But again that would be difficult with a very young client and also understanding at what age you should ask around sexual history because your assumption could be completely off as to when this individual had knowledge about sex or engaged in any sexual activities.

Interviewer:

So it sounds like what you're saying is we need to be better versed, almost on psycho-sexual development so that we know what age is appropriate: do they know, what have they experienced, when their hormones change?

Participant 6:

I think we have a general idea but I think sometimes it's way off but there again even with psycho sexual education you might get it wrong but I think it would certainly help knowing when it's appropriate to start enquiring around topics related to sex.

Interviewer:

So what were your expectations when covering sensitive topics during the first interview, I think we briefly touched on this, you knew you had to get to it, anxiety provoking?

Participant 6:

Yes it was anxiety provoking and I actually noticed that I did a weird thing, luckily it wasn't with a client, it was in a role-play. But I think I touched something, I don't know where, I did something strange and I wasn't aware while I was asking around sexual history that I'm sure must have made the other person

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very uncomfortable because they noticed my discomfort. But I think now I don't really do anything I quickly ask the question and then move on, to be very honest, unless it's an older client and they giving me a lot of information and then I ask around that but if they are very reserved I won't probe anymore.

Interviewer:

So what happens if a male arrives and says I have erectile dysfunction, how would you deal with that?

Participant 6:

That would be difficult especially if we have just met I don't know how to be honest. I can say I would like to but I don't know when I'm actually sitting there what I would actually do. I think I would ask questions around it in a very unengaged manner, very distant because I know I have to professionally. The personal aspect would be taken out of that and as such it would make it difficult for me to empathise because I would be distancing myself.

Interviewer:

So if we look at some of the things: you rushed over it, overlooked, avoided?

Participant 6:

Reworded it inappropriately, where it actually doesn't answer the question;

Interviewer:

So what would you do differently when broaching the subject of sexual health?

Participant 6:

I would ask directly. I would not look for other words to substitute to make it easier, because it's not making it easier for them it's making it easier for me to ask. So I justified it by saying it makes it easier for the client, in fact it's making it easier for me to not be direct. So I think that's the best.

Interviewer:

So how do we get to a point of being direct about it, do we need more education, do we need to normalise the topic?

Participant 6:

I definitely need education with the client, the importance of bringing it up, definitely a lot of exposure, to desensitise it for oneself.

Interviewer:

So what do you think would be helpful within your training to equip you to deal with sensitive topics around sexual health?

Participant 6:

I think to be given the link between it, I think we were but I didn't catch it, to be given the link right in the beginning and not find it out ourselves of why it's important because I think if we know in terms of objectively of why it's important it doesn't seem like it's an invasion of one's privacy as just asking that because it's on a piece of paper and you don't understand why.

Interviewer:

So a better understanding of what am I trying to understand about this person.

Participant 7

Interviewer:

If we look at the knowledge of the interview process and the content what was your experience when conducting your first interview with your client....generally?

Participant 7:

As a whole, the very first time, it was anxiety provoking to ensure that all the information needed was made available, just to make sure that I covered each and every aspect.

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Interviewer:

So do you think that your anxiety was around needing to cover the entire content?

Participant 7:

Yes to make sure that all the important information was provided and that I didn't miss anything especially what was being said by the client in terms of me having to ask the questions.

Interviewer:

So did you go through a process of orienting your client, to the therapy process and specifically around sensitive topics, did you do any orienting around that?

Participant 7:

No not around sensitive topics. In the orientation process: we are going to collect. It was just made mention to the client that information will be gathered, family, school, education, career etc, but no specific mention that it might be sensitive information.

Interviewer:

Do you think you were adequately prepared for conducting your initial interviews with the goal of acquiring the person's whole psychological history?

Participant 7:

The very first one I saw I would say no, simply because in my mind it was more getting the right information. Also conducting an adequate mental state examination, so at that stage it was trying to negotiate: you're asking the person the questions, you're trying to get the information, trying to assess the client, so yes that was the problem with that.

Interviewer:

So do you think training prepared you at all for the interview, schedule, did that assist you? The structure, did that assist?

Participant 7:

The structure did assist you know..... reading about it helps you so much but eventually it becomes a practical experience in that the more interviews you carry out the better you are at understanding the gathering of information.

Interviewer:

So only experience really can assist you?

Participant 7:

In my opinion, yes, the literature is helpful but I think only experience is the best help.

Interviewer:

So when you got to sensitive topics did training help you with dealing with sensitive topics?

Participant 7:

No it wasn't from training it had to be my own comfort to ask the question and hide my anxiety around asking the questions around sensitive.

Interviewer:

So were you anxious to ask around sexual functioning, sexual history?

Participant 7:

I must say the first two clients I saw at the clinic were child clients so I definitely had to avoid that, the third one was an adult and this was the first time I had to ask this question. I was hiding my anxiety and listening to what was being said.

Interviewer:

And why did you feel that anxiety around asking specifically sexual history?

Participant 7:

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I think because it's not a topic you discuss with just anyone and being a new clinician I didn't have the confidence in order to ask that question without showing my anxiety. So now I'm more comfortable with it, I ask on a daily basis I feel more confident around questioning but I think it stems from my confidence as a clinician.

Interviewer:

So not in particular to your own challenges around sexuality or sexual issues, more around being a new clinician?

Participant 7:

Yes as a new clinician, I think that's what it was.

Interviewer:

So actually having to speak about sexual history, sexual functioning, sexual health, that was never a problem?

Participant 7:

No that wasn't the problem, even back then it wasn't a problem it just was that I was a new clinician, I had to navigate the water in how to formally ask the question and some of the answers they were going to give to me.

Interviewer:

What were you afraid of, or what was it that created the anxiety in having to ask about that? What were you concerned about, besides that fact that you were a new clinician?

Participant 7:

I think the problem was that I didn't have the right to ask the question back then, and also it was difficult to talk to someone that was brand new to me about something that is such an intimate part of their lives.

Interviewer:

But did you feel comfortable about speaking to them about suicidal thoughts, alcohol use, drug use, over counter medication?

Participant 7:

The only other one was asking around forensic history, had they had any prior arrests etc.

Interviewer:

But talking about suicidal thoughts that could also be seen to be quite intimate and quite personal?

Participant 7:

Yes probably it was intimate and personal but there was quite a psychological background as to why I was asking that question, so that was important to my work. So the forensic history of had they been arrested previously. Had they been sexually active in a normal sense... that had nothing really to do with my practise.

Interviewer:

So then it's about understanding as to why questions are asked, as you said you found there was a psychological backing to why you were asking about suicidal ideation or alcohol abuse. So does that mean then... that you didn't perhaps at the time see the importance or the relevance of asking around sexual functioning and sexual history?

Participant 7:

Thinking about that probably yes perhaps I wasn't bound by the need to understand the sexual history in relation to their psychological functioning.

Interviewer:

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That's very interesting. So it's about: do you understand why we are asking these questions because we've been given the intake interview and all these things we have to cover but do we know why and the importance and how do they link.

Participant 7:

I know why we ask about suicidal ideation and I could tell you why we ask about substance abuse but then I couldn't tell you about forensic history or sexual practise, now I understand.

Interviewer:

So what are you understanding now of why you ask around these topics?

Participant 7:

It takes me back to the work that we do here now is a lot in personality and trying to establish a grounding from early on where the child, right through their childhood, that person's needs are met or not met, that is something I regularly ask and the various responses you get.

Interviewer:

So what you're saying is through experience not through learning, it's through experience that you've realised that there is an importance in asking around sexuality and sexual health?

Participant 7:

Oh yes, the more experience leads to that, so the more you get answers about it the more you find literature that links up to what you've found that literature forms the foundation of what you've found.

Interviewer:

So now would you say that it is important and relevant to ask about sexual functioning, sexual history?

Participant 7:

Yes now I understand why it has to be the whole package.

Interviewer:

Yes because it builds a picture of a whole person.

Participant 7:

Yes and sexual history provides direct information about needs going unmet, trying to conform to social norms, now I can see that from a different perspective.

Interviewer:

So do you think it would have been helpful to have more understanding around: 'ok this is why I'm asking this'?

Participant 7:

So basically, if I have to answer your question: is in M1 give me the interview sheet and go through that whole thing with me. Tell me why are we asking about sexual history? If the client says this, what is the possibility of that meaning.... yes so I think that would be helpful.

Interviewer:

So in M1 training we are told about the importance about family history and we're told the importance about question around suicidality and we're told that and yet the part about sexual functioning and sexual history is omitted, isn't it?

Participant 7:

Yes it is.

Interviewer:

So in your interview, we go back to your third client, an adult client, when you broached the subject, trying to gather information about sexual history, were there moments that initiated discomfort?

Participant 7:

For me it was the very first time I was going to ask this question so yes my anxiety was great. My voice must have been fine, I asked the question last but I didn't seem to observe any apprehension in her

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response. There was no time lapse when she answered the question in the same tone as she answered all the other questions so maybe my anxiety wasn't as bad as I thought.

Interviewer:

So you weren't aware of any major facial expressions or gestures that showed discomfort?

Participant 7:

No. She wanted to tell the story and one of the things that made me bring this up was that she told the story the same way as she had told all the other stories.

Interviewer:

So for her it was quite normal - it's part of her life?

Participant 7:

So I'm assuming that part of the orientation and gathering information on family history she didn't seem to hesitate when I brought the subject up.

Interviewer:

So then if you think about gathering information on sexual history, sexual functioning do you think there are issues around culture, gender, language differences that can affect the working alliance that come into the room, for you?

Participant 7:

My personal opinion: I find that question to be much more easily asked to males, I'm not sure why, but I think they are much more open to talking about their sexual lives. I do find it difficult to ask this question of males or females of my own faith because it's not something we talk about, not that it's taboo, but it's not something you randomly talk about and probably being a Muslim girl asking a male or female this question I find it can be anxiety provoking.

Interviewer:

So that's cultural and religious?

Participant 7:

Yes cultural but more religious but gender I have found it much easier to ask males.

Interviewer:

That's interesting why? As you say they are more open to talk about it?

Participant 7:

I think because they're not so startled when you bring the subject up.

Interviewer:

What's a woman's response generally that you've found?

Participant 7:

Generally they seem to be normal but I had one or two clients who don't want to discuss that and I try and explain that I'm trying to get a whole picture of them. I just find males respond far better to the question. I don't know if they want to talk about their lives more but I do get much more open responses from males.

Interviewer:

So when you approach a male or a female what is your expectation, because that seems to be quite unusual that most people find it easier to talk to a person of the same gender. So it's interesting that you find it the other way round and is that in your initial approach or has it always been like that or has it been through experience that you now find males easier?

Participant 7:

I think the overall experience I have received from females here I find it much easier to relate to males.

Interviewer:

Are females more guarded?

Let's talk about sex

Participant 7:

I think they are more guarded but I think it's not a topic which they openly want to discuss, I think they come in to discuss their mental health so there is a difference for them between sexual health and mental health. So for them they don't see the link it's just a problem talking about it.

Interviewer:

So at times do you feel that it could be an invasion of privacy or do you feel that it's just part of history gathering in talking about sexual history?

Participant 7:

It may not be an invasion of privacy but in the process of gathering information that question could be asked at a later stage. If you have someone so severely depressed it could be difficult to ask them that question.

Interviewer:

So do you feel that sometimes it's relevant in an initial intake and other times it's not, that they might need more rapport to be built?

Participant 7:

I think it's relevant always and I think rapport is really important in questioning. However, when it comes to certain presentations in front of you, you have a certain obligation as to whether this person is able to provide you with truthful and responsible account of what it is that you want to know and not just something that is going to end it... the topic.

Interviewer:

So it's discernment?

Participant 7:

Yes and you have to use your clinical observation in that, it's important to every single client.

Interviewer:

So it does need to be addressed?

Participant 7:

It does at some stage in your initial intake.

Interviewer:

So what skills do you think create a good rapport and preparing in getting to this topic, what skills do you use personally, rapport to be able to ask around sexual history?

Participant 7:

I think orienting them is very very important, each person's structure is entirely different. Through orientation rapport is being built, so although we may end up talking about something sensitive today it is important that they come back and with consistency rapport is being built and assists with sensitive topics.

Interviewer:

So at the time when enquiring around sexual health what were your thoughts around working alliance?

Participant 7:

So if you look at the intake form the sexual history is further down form so according to the guidelines it's been structured in such a way that you manage to build some sort of alliance with an individual. So placement of that question is very important simply because it's sensitive information and intimate and once someone talks to you about their family and their relationship that alliance is somewhat improved.

Interviewer:

So you think it's placed in the right position?

Participant 7:

I do think it's placed in the right place but once I've talked about it earlier I can then navigate around it.

Let's talk about sex

Interviewer:

So again going back specifically to sexual functioning and sexual history gathering what do you think helped you the most, your theoretical training or your personal paradigm?

Participant 7:

I have to admit my personal paradigm first definitely based on that I could dig into literature and understand the reason behind why we ask the question.

Interviewer:

Do you think the theoretical training was lacking in that area.

Participant 7:

Maybe we would feel less anxious and less conscience about the sensitivity of the topic if we were taught and made to understand the reasoning behind why we ask these questions.

Interviewer:

Definitely. So looking back at your first interview then, were you anxious about it? Did you rush over it? Did you avoid it? Were you at ease with it? How would you describe in that moment, what did you do?

Participant 7:

I avoided it up until the very end. The irony behind it is that client is like the 99% of the other clients I was talking about where I could have asked her half way through the intake and would have had no problem with it based on her response, because by then a good rapport had been established, we had a good vibe. But because of my own anxiety I put it off right until the end, we were trying to avoid it at all costs but eventually we got to it.

Interviewer:

Did you rush through it or were you able to stay with it for a while?

Participant 7:

I was forced to stay with it for a while because of the content of the point she was discussing, so I think I would have rushed through it if it were not for her discussing.

Interviewer:

So if she had answered one or two questions there would have gone tick, done.

Participant 7:

Yes I would have said ok this section is done, let's move on and if it comes up in the future then let's deal with that so yes I think definitely avoidance.

Interviewer:

So what would you do differently when broaching the topic of sexual health?

Participant 7:

I think the more I do it the more confident I would become and you learn to pick up more on what to elaborate on.

Interviewer:

So more skilled?

Participant 7:

Yes more skilled and you become more confident in your skills as well, so again it goes back to knowing the reasons behind the questions. But how do you develop that, the actual questioning skills and maybe going back to orienting the client and what to say in the beginning - we're going to gather a lot of information so maybe highlight some of the information to be gathered so maybe that's what I should be doing as well.

Interviewer:

So what do you think would have been helpful in your training to have equipped you better, so a list of things that could have helped me deal with gathering sexual history?

Let's talk about sex

Participant 7:

First ask the questions you remember get yourself to vocalise it, hear what you sound like, record yourself so you're making sure your tone and your pitch, so although you're panicking on the inside you're taking to appear calm on the outside.

Interviewer:

So discussing it with the class?

Participant 7:

Yes discussing it in the class, yes simply just playing it to someone and having that person rate your performance, and understand if you're coming across anxious so when at the time of working with a client you're less anxious about it.

Interviewer:

So perhaps a potential lecture or a workshop?

Participant 7:

Overall it covers the clinical interview but to specify those types of things I do believe that asking them more and more frequently, before you have to ask the client, it becomes more familiar.

Interviewer:

So in your role play, when we were broken up into groups, do you remember asking around sensitive topics?

Participant 7:

No I avoided it even in role play, even with the people who were in class with me, I know I avoided it, I never thought about it until today, so thought provoking stuff.

Participant 8

Interviewer:

If we look at your knowledge and the interview process and the content of your first interview, what was your experience when conducting your first interview with your client? So in general, not with regard to sexual functioning and sexual history, how did you find your first intake with your client, in general?

Participant 8:

Very anxiety provoking because you had to remember a lot of things. There was a lot of structure to it so we spoke about a lot of self talk in the process of interviewing and sometimes that got in the way because you'd say 'I forgot to say this and I forgot to say that'. I felt writing down while we spoke was helpful however you lacked that engagement with the client... so just the structure of the interview remembering what to say, when to say it.

Interviewer:

Was that helpful or not?

Participant 8:

I felt it wasn't helpful, I felt like just going with the flow as the client spoke was a better way of gauging stuff and then in the follow up session of maybe I didn't focus on this in the last session and then go back. I think remembering too many things and making sure to cover this, you lose the moment with the client.

Interviewer:

So did you go through a process of orienting your client to tell them what was going to happen and if so how did you do this?

Participant 8:

Let's talk about sex

Yes I did in the beginning, what I had done was write down the stuff I needed to cover like introduce myself, confidentiality, duration, fees, I try to get that all out of the way.

Interviewer:

So you said you prepped before so you knew what you were going to do?

Participant 8:

Yes so what I did was I practiced, rehearsed with someone I knew and was familiar with, and that also helped just to get my own style of things because before I was very rigid with asking things, so that was helpful.

Interviewer:

Did you orientate your client with the understanding of having to deal with sensitive topics?

Participant 8:

I think when I got to the sensitive part I knew I had to, I made sure to say: ok now I going to ask a bit more sensitive topics and then go in like that. But I was always nervous when I got to that point because I knew what was coming next.

Interviewer:

Ok tell me more about that, what was coming next?

Participant 8:

So I said: I am going to ask you a bit of a sensitive question about yourself and then I would have to look at my page, almost like a crutch to settle my nerves and my anxiety, just to write down the key points and then go into the question of: ok you're in a relationship when did you start getting intimate and I would try and skirt around the topic.

Interviewer:

So did you find it quite challenging?

Participant 8:

Yes definitely challenging to say it in a way that wasn't an invasion of their privacy, or would make them feel uncomfortable because I do understand the first time seeing me and sharing some of those sensitive details would not be easy for someone being there for the first time and also for myself whose not comfortable speaking about it because of my upbringing I wasn't socialised to just bring it up, I didn't know how to so in that regard I did find it quite challenging.

Interviewer:

So do you think you were adequately prepared in training to be able to conduct this initial interview specifically with regard to covering sensitive topics?

Participant 8:

No I don't think it was focused on really. The only time I was exposed to it was in our orientation week and that was only one day and the reason I found out I couldn't do it is because I had to do it. The role-plays allowed me to learn from other people as well, different ways of doing it and saying it but I was stuck. At that point of the interview I felt stuck - I didn't know how to word it correctly. I fumbled, mumbled, lost my eye contact, looked down, so I felt it wasn't really addressed sufficiently, that specific area. You had to learn from other people or find out different ways of 'how would you do it' or 'how would you say it in a way that's not going to be offensive'.

Interviewer:

So in comparison would you say then that other sensitive topics are covered better in training than questioning around sexual functioning, sexual history and sexual health?

Participant 8:

Yes, I think what was told to us was that you should just say it but they didn't tell us how to say it.

Interviewer:

Let's talk about sex

Or maybe why?

Participant 8:

Yes. Why was it so important to take that down? I think informing us better would be helpful.

Interviewer:

So you were familiar with the process of what was expected of you but then personal challenges for you around questioning around sex, what were your personal challenges to do that?

Participant 8:

I think just asking about their sexual experiences, their sexual libido... personally I didn't know what to say about that, because I personally was not sexually active while doing this so I felt very inexperienced. I didn't even understand how was their first time, how frequently... I was young, I didn't know. So that aspect of itbeing raised in a catholic home and the golden rule was to abstain. It just went against my religion, especially speaking to someone who was experienced, I wasn't, same age, it was quite challenging in that regard.

Interviewer:

So it sounds like that because you were not familiar with the subject or the topic you didn't really know how to deal with it?

Participant 8:

No one ever spoke to me about it unless it was friends who had been through it. I was exposed to the whole idea of sexuality, very briefly, in Honours, when I took gender and sexuality with Steven.

Interviewer:

So would you say in Honours it was the first proper introduction to sexual discussion?

Participant 8:

Yes, the introduction to the mechanics of sex, orgasm. But then I also struggled to communicate it and to relay it. I was still shy and anxious about it, and then it wasn't an interview, you're just learning about it.

Interviewer:

And still you were quite uncomfortable talking about it. So in your home did your Mum or anyone in your family sit down and tell you what sex is, or this is how babies are made?

Participant 8:

I think I learnt it in school, books, TV, friends who were pregnant, sharing with me, guy friends but nothing really that I had to investigate or I had to ask.

Interviewer:

So no one had a free conversation with you?

Participant 8:

No not really, the information I have is from different sources.

Interviewer:

So it was just 'by the way'.

Participant 8:

Yes. Just saying 'I did this or I did that', I didn't understand.. Yes I could understand where they were coming from but for me it was something I could do yet until marriage so different sources helped me. My Mum just sat down and spoke to me, she just said: do I need to have this talk with you and I said no I'm fine, that's sufficient, or she'd say stuff like 'you need to be tested', I think one of our friends was pregnant, she was a teenager, 'you need to take care of your body, go for HIV tests regularly, you can't just trust a guy'. So that's as far as it went, nothing on sexual exploration, nothing like that, she told my cousin to go on the pill if you're sexually active, so nothing with me one on one so I learned everything from other people telling me and me asking questions.

Let's talk about sex

Interviewer:

So when it comes to questioning around sexual functioning, sexual history, sexual health is there an understanding of why you need to ask that or does it seem irrelevant for you?

Participant 8:

I think I didn't see the need for it then to be honest. I didn't know why... I just did it because we had to do it, it's part of the questioning to ask all these questions to get a picture of this person and where they're coming from. Then as we went along looking at the different problems that people had and maybe the diagnoses linking it to that, their first sexual experience was like that, so in learning and getting experience I then could see the need for it and the importance of it but no one really told me exactly the purpose for it. But I could after some time when trying to conceptualise or formulate the person I realised it did play an important role in the person's dynamics.

Interviewer:

So now do you think you see it a little more clearly, it's not just on the list and you have to do it, do you now see the importance of asking the questions?

Participant 8:

Yes I feel it is important and it is necessary and that most of the clients we see, you may be more anxious than them. They may be comfortable with themselves with their sexuality and can be open and honest with you, so I think we should not have a preconceived idea about it. So for me I couldn't just go in assuming that this person will not want to tell me and now even when I find it difficult to say I'll find a way that I'm comfortable enough to talk about it. But also to be genuine, go into it with a sense of curiosity as opposed to being very fearful of it and just make it like a conversation and I think most people are open and honest.

Interviewer:

But it's almost that through your experience comes the understanding of why?

Participant 8:

Yes it was clearer.

Interviewer:

There again it was just on the list, it has to be covered but there's no real understanding?

Participant 8:

And not even the how. No one ever told you how, and as I said it was pure supervision I think around that learning from other people modelling I think that assisted me, examples and even practising it because being aware of where your weaknesses are. Perhaps you actually want to overcome them so you practice it and find other ways of handling it and as I grew as a trainee other challenges are more important than that just seemed to slip away and other areas of the therapeutic relationship became more important than that.

Interviewer:

It's almost as if I get the feeling that if it wasn't ignored, if there was a little bit more input, it would normalise it more for us as trainees but we get training in suicide, alcohol and substance abuse but there's not much with that, why?

Participant 8:

They don't really orientate you to it as fully as the other areas. It's almost like you're just thrown in the deep end and figure it out on your own, whereas we are in training so we should be training in how to do it. So in that regard I felt it needed a lot more attention especially being a first interview and this is what you're going to do for the rest of your life, if you choose to and you need to know how to do it well, how much better if they focused on it.

Interviewer:

Let's talk about sex

So can you describe some moments that initiated any discomfort for you or for your client when you were trying to ask around sexuality, sex, can you remember any of those moments?

Participant 8:

I felt that when I stumbled or hesitated that caused the client to react, either laugh or look away.

Interviewer:

So it caused a response in your client because of the way you reacted?

Participant 8:

Exactly. Whereas if I had approached it in a more confident way they would have been able to answer but I think from their part they were still trying to see where they stood and also because they knew I was a trainee that also impacted on how they responded to me.

Interviewer:

In what way? Why do you think that it impacted on how they responded because you were a trainee?

Participant 8:

I think at that stage, for me, I thought that I was too young and just also other dynamics like race, I'm young and a female.

Interviewer:

How do you think race played a part?

Participant 8:

I think when it comes to race, it depends on how they were raised or how they interact with other people of other races would impact on how they would interact with me and obviously test or push the boundaries at some point. But I think some races would not be so open in sharing their experiences, especially their sexual experiences with someone who's a female and young so maybe they felt that I did not understand or could not relate. So maybe they wouldn't answer as truthfully, would just say yes or no and not be forthcoming as I'd hoped. So as soon as it's out of the way, so for me it was, begin there, out of the way, answered yes or no. I wouldn't probe for more information so I would get my answer and carry on with the interview. I think that also they could sense because I rushed through it.

Interviewer:

Ok so you rushed through it?

Participant 8:

Yes. But in other areas I would take my time, get more information. I think they would be able to tell if I was anxious because of how I would speak or because I mumble, lose eye contact, fiddle with my page. My first interview was with a teenager, it think it was quite different with a teenager.

Interviewer:

Why? Tell me about that.

Participant 8:

Because I wouldn't know if they would be shy, just as shy as me, to speak about things like that, if they couldn't ask their parents why would they ask me? There was a lot of self talk going around with me as to how I was going to ask the questions around that.

Interviewer:

And were you able to ask eventually?

Participant 8:

Yes eventually I was able to ask by tying it up with a relationship: e.g. do you have a boyfriend? What kind of things do you do together? Do you do some intimate things? Or I will take another angle: e.g. in school do they ever talk about sex, what do you know about sex? Have you had any personal experiences, that was only later.

Interviewer:

Let's talk about sex

A few sessions later?

Participant 8:

A couple of sessions later I used different angles to get to the same point but initially I couldn't ask it, I found that they might ask 'why are you asking me this'?

Interviewer:

So do you feel that building rapport is quite important when questioning about sexual functioning, sexual history?

Participant 8:

I don't know if it would be better to do it in the first session or as the topic arises maybe, I'm not sure, I don't know if it would be different with teenagers?

Interviewer:

It's interesting because if we're looking at a person having the whole part of themselves. So we ask about emotional stuff, physical stuff, sexuality is part of that so it's very difficult to know... do we just need to ask it in the interview because we're gathering history, or do we need rapport because this is sensitive? This is what is so interesting... when is the right time to do it?

Participant 8:

One's not too sure, do you start with it? Or right at the end of the interview? It is quite tricky but I think as you get to know the client you get to almost being able to judge when to talk about a sensitive topic, like tests or trials, see how they respond to that and then ask about it, but you don't get taught that either. You just want to get that interview done, get all the information, your supervisor needs to see it, quickly talk about it and move on.

Interviewer:

Did you notice any gestures or facial expressions from you client when asking around this topic?

Participant 8:

Yes in the first instance, she would look down, smile, be quiet. I would then comment on her being quiet, we may then carry on with that or I would just leave it all together because I'm pushing too much so let me come back to that, but sometimes I would forget.

Interviewer:

So in relation to things like culture, gender and the effects of language differences, how do you think that this plays a role, because you've briefly mentioned that, what is more difficult, cultural differences, gender differences, age differences?

Participant 8:

I think for me, gender and age.

Interviewer:

More than culture?

Participant 8:

Yes more than culture, because with culture you can more or less have an understanding of culture, you have friends from different cultures so you know how they do things. But I think gender plays a role because I'm a female and I'm young so automatically if you're with an adult, say male, depending on how comfortable they are with you, depending on the relationship you have with them but I think it would be difficult for me because I would think would he actually tell me? How would he view me in that moment, would he also feel why am I asking that? Why is that relevant? You're so young. So almost how others would perceive me when you're asking that and then also I think about my upbringing and not let it affect the interview, so that was also a challenge for me to overcome.

Interviewer:

So is it easier to speak to a female?

Let's talk about sex

Participant 8:

Yes female maybe my age or younger. I think adults, females depending on how they relate to you but I think I would find it difficult.

Interviewer:

So do you think any of these aspects influenced your clients in actually telling you truthfully, do you think this did affect your clients?

Participant 8:

Honestly I'm not sure, it could have but I wouldn't really know because I wouldn't ask. I could make assumptions in that moment, of gosh I messed up here or why did I say it like that? It would throw me off and I would think I'd ruined the process. Sometimes it could be a good thing, we were both laughing, it lowers the anxiety a bit and then you could talk about it but I don't know if I can speak on their behalf but for me maybe it did maybe if didn't. You would only find out in the next session while talking to them or if the subject comes up again, then you find out, and looking at their history is also important, finding out if it is a big thing in their lives or if it's not.

Interviewer:

So do you feel when you ask around sexual health do you feel like it's an invasion of their privacy, how do you feel about that actual questioning, I know we've touched on that briefly but do you feel it's an invasion of privacy or is it just something else you need to cover, how do you personally sit with that?

Participant 8:

Initially I thought it was an invasion of privacy and something private and sensitive but when I thought of it in a different way I found it easier, tied it to their health and what they're going through then I could relate to it more, open up more.

Interviewer:

So if there's more meaning and understanding then you feel more comfortable asking because you know why you're asking, it's not just randomly asking about your sex life?

Participant 8:

So if I tie it to that but not just say because I have to say it, I feel then what's the point?

Interviewer:

That's interesting. So were you aware of when you were questioning around sexual health or functioning or history, were you aware of any moments that affected the working alliance?

Participant 8:

Not really because I think my being genuine also helped so I don't think it hindered me in any way, they could see that I was human and that when I was a teenager I also got shy and nervous.

Interviewer:

So that's like a skill that you could draw on just being human and genuine?

Participant 8:

Yes being something that you're not or trying to play that role, you only get stuck. Just to be yourself in everything that you do, use yourself as the tool because they can tell and as I grew I loved that with the structure. But it has to come from a place that you're genuinely concerned... you genuinely what to know about this person and you're actually showing them that they are important ... the only way to do it is to be yourself.

Interviewer:

What knowledge and skills did you draw on when trying to frame this topic of sexual history gathering?

Participant 8:

Knowledge of their age so age appropriate language to use, better questioning skills, how to say it, that helped.

Let's talk about sex

Interviewer:

I think one of your skills that you used was being genuine.
So what strategies did you employ to help with these obstacles?

Participant 8:

Being genuine and also, not practice but forcing myself to overcome that challenge, not looking at it in fear but force myself to delve into it, research about it, ask people about it, finding ways to doing it saying it. Finding out the why part for yourself. Because what happened after that was one of my colleagues gave me a website where Christian Catholics were talking about these sexual experiences especially if you're with your husband and it's your first time just speaking about it because in our religion it's very different you must just abstain that's it no why you must abstain and that just opened me up to so much more information.

Interviewer:

More knowledge? So did your theoretical training help or was it your personal paradigm?

Participant 8:

Yes my own personal paradigm. Not because I was forced to do it but because I'm the type of person that if I'm given a challenge I don't give up I will try to overcome it. I find that this is one aspect of my interview skills needs work so I will try and improve in that area so I was more so I was more determined and confident but it was more my own personal paradigm that played a role. Theoretically... not really because it's not personal enough because I need to connect with the client.

Interviewer:

So before your first interview what were your expectations when covering sensitive topics specifically sex?

Participant 8:

Different ways of saying it firstly how to say it, tone and all that.

Interviewer:

So was there any anxiety around that? Did you want to avoid it?

Participant 8:

It was anxiety provoking. I felt I wanted to avoid it. I felt, should I even ask this teenager this? My expectations weren't negative but I had to do it so let me see how it goes. I have been practicing, it was rocky at first and then just the genuineness and all of that and speaking aloud about the experience was important.

Interviewer:

Sharing as well, was helpful?

What would you do differently when broaching the subject about sexual health?

Participant 8:

Now I would know how to bring it in using what they say or using the different questioning skills not just straight out of nowhere there must be a flow to it. It mustn't be abrupt and also just checking with the client, where are they? Are they able to communicate freely about other things.

Interviewer:

So as you say addressing discomforts, checking with your clients?

Participant 8:

Are you able to open up - I'm this age, how do you feel about being in a session with a female? Checking with them and seeing where they are.

Interviewer:

So what do you think would be helpful to you within your training to assist you dealing with sensitive topics such as sexual health?

Let's talk about sex

Participant 8:

In our M1 training they should focus on who are the ones that are comfortable and the ones that are not comfortable, just separate the ones that can do it and the ones that can't do it and understanding the reason why they can't do it and help us, guide us, perhaps let us observe them doing it in different ways, refer us to some videos, resources that would help us, and then also telling us the why part, why it is important.

Interviewer:

More time to be spent on discussions?

Participant 8:

We just brushed on it and we didn't really focus on it, ok you've done the role play now so you should know how to do it and it was just left there and it was your own personal and individual journey.

Interviewer:

In role-plays how did you find that process?

Participant 8:

I think it was helpful because I didn't realise how difficult it was to talk about it until I was put in that spot.

Interviewer:

So your group actually went through sensitive topics.

Participant 8:

Yes.

Interviewer:

Because many don't.

Participant 8:

Exactly, so that was helpful to have actual been through that, just their support.

Interviewer:

So peers support as well?

Participant 8:

Peers support is important because you're in it together so being exposed to it and getting practice because it would not have known I was uncomfortable if I hadn't done it. So role-play was a good thing but more focus on the debriefing part of it would be helpful.

Participant 9

Interviewer:

If we look at the knowledge of the interview process and the content what was your experience when conducting your first interview with a client, just generally not just about sexual functioning but how did you find that process of your first interview with a new client?

Participant 9:

I think it was ok, I was at King Edward Hospital as an intern counsellor so I've got a bit of experience there but I think it was the camera. I think one of the biggest things for me is the camera and I also think for the client to be honest because you have to obviously tell them you're recording so that was a big thing for me. It was ok, the structure of the forms I don't like especially with the sexual history it pops up in between the group questions and it is awkward, my first client I had here was a child, my supervisor wanted me to interview the parents first.

Interviewer:

So you did a parent intake?

Participant 9:

Let's talk about sex

Yes and you have to ask them also about their sexual history and how intimate they are and I find that a bit irrelevant, it could be, there may be some issues there but I still think it's irrelevant.

Interviewer:

How old was the child in that particular interview?

Participant 9:

He was turning ten so he was 9 years 11 months.

Interviewer:

So in that particular case it wasn't really relevant but did you still feel that you had to get through all the little boxes?

Participant 9:

Yes, I didn't feel that I had to. What it did, because the form we have is not really to get collateral, it's not really a good form so I made my own using a colleague's form, she's placed at a school and they have an intake for parents so what I did I took pieces out of it and mixed it in with what they had just to ask them but it was ok in general just to get through that part for me.

Interviewer:

Is that the only client you've had so far?

Participant 9:

No, the next one I had was a male, a white male my age, so that was awkward, I'd spoken to a supervisor before - there were three of us and I asked him how to go about asking certain questions about sexual history and I found for me... I asked him how was his intimacy in his relationship. That word I feel better asking. But the problem is that they ask you to clarify what you mean about intimacy so it didn't work out, I forgot to say sexual intimacy so I just found it awkward.

Interviewer:

When your first client comes in do you orientate them to the therapy process how do you do that? Telling them you're going to be gathering a range of history, do you do that?

Participant 9:

Initially we do we go through the content form then I put the camera on then I say to the person this is what we're going to be doing - I'm going to be asking a few questions. We're supposed to start with free speech so I'll give you some time to tell me what's going on and then go into each question. I try not to be too structured, I really hate that form but because we're new it's difficult because you want to have something to reference to.

Interviewer:

Do you also find that in the back of your mind you're thinking I need to check medical stuff, alcohol, drugs, sex?

Participant 9:

Yes to make sure but I don't like that. When you're sitting and just doing it without a form and without being watched and you can do it a bit more freely and if you make a mistake you don't feel so 'watched'.

Interviewer:

So in that orienting process are you able to say to your client that I'm going to be asking questions that may be a bit difficult.

Participant 9:

Yes I think when I get the MSE I tend to say that, because I ask the sexual history before the MSE so when I get to that I say some things might be difficult.

Interviewer:

So the male client that you said was a bit awkward because of the age, were you able to get to speaking about sexual history or not really?

Let's talk about sex

Participant 9:

I feel like I tend to, once I have an answer I go off of it, I don't probe anymore I think because it's a bit awkward. Yes I did get to ask it, I said: is your relationship intimate with your girlfriend? It was a new girlfriend, he asked what did I mean? I asked him if he was having sexual intercourse and he said yes so we didn't go further than that.

Interviewer:

Do you think you were adequately prepared for the process of conducting this initial interview with the goal of acquiring the persons psychological history so have you been adequately prepared in how to deal with each step?

Participant 9:

I think moderately because we did role- play in the first month but I don't think we went into sexual history to be honest with you. I was part of the process so it was one of the questions asked in role play, it's not as hard.

Interviewer:

But did you do it in the role-play?

Participant 9:

Yes we did because we had to do a full interview.

Interviewer:

Just for interest sake, when you did that role play were you in a group of two or three of you?

Participant 9:

Our first one was three but then after that we did it with two but it depended on the number of us because there were thirteen of us.

Interviewer:

So in that role-play, even then talking about sexual history, sexual functioning, even though you knew it was a role-play, how was it in that space? Was it glossed over?

Participant 9:

We asked it but we never did it in depth, it just didn't seem relevant.

Interviewer:

It almost seems that you're not sure that part of the history taking is relevant or if you have to do it with every client or you have to be discerning?

Participant 9:

Yes that sounds right, I know there's more to the sexual history. There are different parts in brackets pertaining to sexual history, e.g. puberty, how did you find out about it etc. etc. I never do that because maybe I feel it's not relevant but maybe I should.

Interviewer:

That's interesting because what does sexual history and sexual functioning cover as you say? Does it cover adolescence, hormonal changes? How did your parents tell you about sex?

Participant 9:

Another one that comes up is first sexual experience, I don't want to ask that then later on in the MSE... it asks about libido.

Interviewer:

So you perhaps feels it's disconnected, perhaps not clarified? Are we talking about sexuality, what is that umbrella covering? Not everything pertains to a particular client.

Participant 9:

To go through every one of those things is quite something.

Interviewer:

Let's talk about sex

Yes where perhaps it's not relevant to a particular client.

Participant 9:

Both my clients are assessment cases not therapy cases. Do you ask all of those questions, are they relevant? Especially the child not the parents but I asked the questions to see how their relationship was.

Interviewer:

So for yourself the familiarity with the process, understanding the process and your own personal challenges around sexual health, do you think it helps or hinders the process around sexuality, so your own feelings about sexuality?

Participant 9:

I don't think so and that could be a reason why I don't think it's such an important thing. I don't quite know how to answer the question, but I think how I feel about things I don't assume that they will feel the same. So how I feel about it doesn't really matter, so maybe that's why I feel they don't think it's relevant?

Interviewer:

And also maybe it's not wanting to put your own stuff onto the client, not assuming, as you say and I think that sort of question of personal challenges around sexual health, if one has issues around sexuality is it then that much more difficult to raise those issues.

Participant 9:

Do you mean have I had bad experiences?

Interviewer:

Because sexuality can sometimes be taboo to talk about as you said with this man, being the same age, it becomes awkward so what about it that makes it awkward?

Participant 9:

Well that's quite weird to tell you because I'm gay so it was weird for me because you would think that it would be the opposite because you would think if I was asking a female it would be awkward but I think because he was a white male and so far I've only done interviews or counselling with black people some Indians as well no white people until here.

Interviewer:

This is exactly what I want, why do we freeze up with certain things, is it about him being white that it was more difficult than had he been black?

Participant 9:

I think it was how he behaved, he was twenty six but he behaved like a typical teenager, that's how he came across, so I think that's why it was so awkward.

Interviewer:

What part of that was awkward? Was it intimidating, or just different? Uncertainty because you hadn't interviewed a white male? I'm sure will get to more of that so keep it in mind of what exactly about that, would you have been more comfortable had he been a twenty six year old Indian man. So how did you introduce your client to the sexual topic, I know we touched on it with your child and the parents but with your male client how did you broach the topic?

Participant 9:

There was a pause, turning the page: so how is your intimacy in your relationship? He asked what did you mean? I said: your sexual activities with your girlfriend. He said yes, that's how it ended. So when I got to libido I glanced at it and moved on.

Interviewer:

It seems almost like relief? You've ticked the box so let's move on?

Let's talk about sex

Participant 9:

Yes definitely.

Interviewer:

So understanding the purpose of sexual health for the client and the clinician, as you say you're finding that it is relevant, so how well have you trained to understand why we're asking that? So are we being taught that in M1, are we being taught why we need to ask that and what is involved?

Participant 9:

As far as I know we not taught it as such but it think it has come up in one of our seminars but I think it's always very brief we're not taught exactly why we're asking it that's why I say it was relevant with the parents of the child it could be an inter marital problem and could relate to the child. So honestly no I don't know why.

Interviewer:

Can you describe a moment that initiated any discomfort that was perceived by you or by your client, you said there was a pause from you?

Participant 9:

Yes he paused as well I could see he felt a bit awkward, he smiled and I think he also wanted me to go over it quickly, he didn't say much either just it was fine, it was good so I could tell he felt awkward so that made it more awkward for me. The parents that I saw, the mother, it wasn't such an issue for her to speak about it there are obviously a lot of issues with that family, there was not sexual intercourse with them so I didn't want to go into and I feel there's more relevant stuff that you can pick up on for marital problems, abuse for any of that stuff it's not just that that should have the focus.

Interviewer:

So expressed verbally or non-verbally, you noticed a bit of a smile there was a bit of a pause and you felt this awkward moment?

Participant 9:

I think I also smiled and then we moved on, fine talking about substances, personalities, it's such a big jump though.

Interviewer:

So I wonder then, there seems such a disconnect between topics, so if that has to be covered, so I wonder if perhaps in the orienting phase saying to a client we have to cover a range of information and some things might not seem relevant but I'm trying to build an overall picture?

Participant 9:

I tend to try. I know with the parents of the child, the Mum that I saw, I tried to talk about their marital history I feel that flows a little bit more because while they're talking you can ask them about their intimacy, that makes me feel a lot better I don't feel like I'm talking about their sexual history.

Interviewer:

If you think back, talking to her and then talking to you male client how different was that feeling of awkwardness?

Participant 9:

It was much more awkward with the male, I honestly don't know why. I'm very open, I can talk about anything, I just think it's talking to a random person about their sexual history so yes it can get a bit awkward.

Interviewer:

But I suppose, if you think about it, they're coming to speak to you about the most intimate things about themselves anyway their thoughts and their dreams so how different is talking about that?

Participant 9:

Let's talk about sex

I think also for me there's assessment in it but if I think about it you are talking about other intimate stuff but for assessment I'm not sure it's so relevant.

Interviewer:

What interests me is that we're gathering all this intimate information from a person about how they are in the world out there, their relationships, their dreams maybe what worries them and anxiety, that's intimate stuff, so why is it that we separate even in an assessment intake people can tell you things that they've never told anybody before about their worries and anger so why do we separate these questions about sexuality and think that is so intimate and personal, what is happening that this is so intimate and that is not?

Participant 9:

Maybe it's the difficultness of sex, it's the physical rather than other things we're talking about. Stuff that perhaps happened in their childhood, it can be intimate if it happened as a child so long ago but even in the present it's so physical and it's something that we all experience. A client can talk to me about being abused or molested as a child and I have never experienced it but I can sit and listen to it but when it comes to sex or sexual history I'm sure we've all engaged in some form of sexual activity so I think that it's more of a reality for you sitting talking to somebody about their sexual history so I think that's the awkwardness.

Interviewer:

So how do you think if the roles were reversed and you were sitting with me as your therapist and I said to you tell me about your sexual history and sexual functioning, how would that feel for you?

Participant 9:

Chances are I don't think I want to talk about it, depending on what you asked. If you asked me if I was intimate in my relationship obviously I'm going to say yes but what does that mean, so the question is very broad.

Interviewer:

So how broad is it? How deep does it have to go?

Participant 9:

If you asked me more and more questions I would answer them but I would feel uncomfortable, I'm quite reserved in a way I don't just go around talking about sex all the time. I'm very open and can discuss it with my friends so yes I can talk about it but it's not just something I would be so open about especially about my sexuality.

Interviewer:

So it's again how much sexual history, sexual functioning, sexuality do we need to probe to understand?

Participant 9:

You do need to probe - that's exactly what I'm saying. Nobody would know about say... being gay unless you probe.

Interviewer:

But I do think when you answer a question saying you have a 'partner' this immediately, for a lot of people, would already be an indicator?

Participant 9:

That's what I thought but everyone here says partner, even lecturers, the word is just thrown around.

Interviewer:

We're talking about psychologists remember, they know about this?

Participant 9:

So people would have to probe me to get answers.

Interviewer:

Let's talk about sex

So just for interest who does know you're gay?

Participant 9:

Everyone, my family, my friends it's just here that no one knows.

Interviewer:

But it would be different if you were hiding it from the world, you just haven't told everyone in M1: hey I homosexual.

Participant 9:

Exactly. I didn't do that but I thought it may be something that would have been brought up in a conversation but it never has it's been five months now and it never has come up.

Interviewer:

And why should it?

Participant 9:

For me it just comes up in conversation and it would be something that is related to the topic and I would have to say I'm with a female it's usually with people I don't know usually after about two or three months and that's how they would find out.

Interviewer:

But I think the interesting this is, not that you're gay, it's how you feel about disclosure and disclosure about that. This is a personal, private thing whether you're with a male or a female so I don't think the issue is your sexual preference it's how you feel about what's shared and with who and when it's appropriate and it seems to me that it's almost coming over in your interviews of that's what you're feeling towards the person sitting opposite you, what right do I have to ask, it seems like the same kind of things that you're saying?

Participant 9:

It could be, it's been such a roller coaster for me since I came out and all that stuff I had a lot of issues around that from people. Not that I shout it from the roof tops as a lot of gays do, or that I'm ashamed it's just difficult to confront the issues, so I think for both people it's difficult to talk about that stuff, it's very personal and very intimate.

Interviewer:

But do you think it's appropriate to be asking in the intake interview or is it something that needs to come through rapport?

Participant 9:

Yes I do actually because I think especially for therapy unless it's an assessment on sexual functioning but I think for therapy you could bring it up in your third session but we are asked to do it in the first session. You don't even know the person, they don't even know you, it's fifteen or twenty minutes into the session and you ask them are you having sex with your wife or how long is it that you have not been having sex? I'm sure that came up with a woman they don't really have sex, so how long has it been, she's here for her son and I'm busy asking her about her sexual history, so I could tell she felt why she was being asked this, I reassured her that it was just the process.

Interviewer:

So in relation to the effects of culture and gender and language differences and your working alliance and disclosure, especially gender and culture, how do they affect, as you said it was very new for you to have a white male, how did gender affect you?

Participant 9:

I think it was gender but also age, we were the same age and white, I'm mixed, I'm white and Indian but all my friends are mainly white so having a white male, it was almost personal, so he could have been a

Let's talk about sex

friend, I have had a white male before but he was quite old, about sixty, and he was quite open with the sexual history and that wasn't as awkward as this, I think it was more the age than the gender.

Interviewer:

And a feeling of perhaps that we're doing therapy and then we suddenly are kicking into sexual functioning, do you think that could change the whole process?

Participant 9:

I didn't want him to feel uncomfortable especially that it was an assessment to do with a learners licence in the form of an oral, if you think of the referral it just doesn't fit and all the stuff I should be asking him I don't think is on that form.

Interviewer:

And if it was a therapy case and he had come for therapy

Participant 9:

Which he could do because there are a lot of issues that he's brought up.

Interviewer:

Ok so how do you think you're going to deal with that, if he becomes a therapy case, and perhaps these are things that potentially could come up, he's in a relationship he's had a fight with his girlfriend? Do you think it would be different, second, third interview you are now doing therapy with him and there's a rapport, do you think it would feel different for you?

Participant 9:

I think it would because I've now had three sessions with him and on the last one I had, I asked him how things going and he said he a broken up with his girlfriend and he had a new girlfriend and already I felt there was a lot more rapport but I didn't go into anything about sex. I told him we had already covered that so we wouldn't revisit that now, I could have but I didn't so I'm not sure if I was meant to but if it was later say six sessions down the line and we are doing therapy I think it would be relevant, I would be more comfortable, lot more rapport had been built but still I didn't ask about that because we had dealt with that but now there's a new girlfriend so should I have dealt with it? I don't know but later on I think it would be a lot easier.

Interviewer:

Again it's interesting... assessment, therapy, rapport building, appropriate in your first session?

So talking about culture, gender and all of those things how do you think these aspects affect the client's disclosure of his or hers sexual health?

Participant 9:

Here I haven't experienced too many clients but I do think it plays a role, especially the more religious. I know it's not something that they want to talk about, I had this one client at King Edward, there were two of us doing the interview together, we saw this one girl, she was a para-suicide she was twenty one and we asked her about her sexual history. She was very giggly about it she was a virgin and she was very religious so she didn't want to talk about it too much, so yes I do think religion would play a big part.

Interviewer:

And if you knew somebody was religious would that make it more difficult for you to pursue that line of questioning?

Participant 9:

I think it would do it, more because I had to, it wouldn't be more difficult. I would just ask the same questions, but I think perhaps be more difficult for them. It would also depend on their answer to the question... if they were hesitant this would make it awkward for me and I would want to move on instead of probing.

Let's talk about sex

Interviewer:

So then let's look at the twenty one year old that you had. She was giggly and looked like she didn't really want to talk about it. If it came to drug use and she responded in the same way would you stay with that line of questioning even if she was evasive, would you have stayed with it?

Participant 9:

Yes probably because that would be more relevant I would probably want to know or I would carry on and come back depending on how she reacted to it.

Interviewer:

Do you think you would more likely pursue a line of questioning about drugs and alcohol than you would around sex?

Participant 9:

Yes definitely only because in my mind if she was taking heroin that to me is more of a problem than has she had sex or not.

Interviewer:

Except if you think about it a twenty one year old who is very religious and doesn't want to talk about sex or sexuality how much is she at risk for abuse or for not knowing what to do what is expected? What is acceptable what is not acceptable so why do we chose the questions?

Participant 9:

To be honest my worst was this lady, she was also my age, coloured or black and she came to therapy because she was an abusive case even at her age and apparently it had been going on for so long it went back to sexual abuse as a child and for me asking those questions were very difficult. She was crying, it was really hard she was really suffering and you want to talk about sex now and sex before and how it is, so that was really horrible.

Interviewer:

So do you feel it's around invasion of privacy, what hinders your questioning? I know we've touched on it as to whether it's relevant but do you think it's an invasion of privacy, why is that more of an invasion of privacy than: do you use drugs and what medication are you on?

Participant 9:

I think it is an invasion of privacy, obviously they're here for a purpose and we do inform them that we will be talking about certain things but I think it goes back to being personal for me. I would have experiences, they would have experiences rather than an invasion of privacy it's more that relatable factor.

Interviewer:

So it makes you hesitant to probe too much? So if we look at the working alliance then and considering what we've discussed what were the aspects that you were aware of having an effect on the working alliance for example rapport, trust, feelings of comfort. We've already covered that anyway but you noticed that there were areas that were awkward, the smile, the Mum questioning: why we're doing this, you were aware of this? At the time were you conscious of having ruptures in the working alliance?

Participant 9:

Yes I think it was, more with the male, because it felt that this was too soon and I did not want him to feel awkward because there were so many more questions coming, so I just want to rush over it and carry onto the more important stuff.

Interviewer:

So what happens if somebody walks in for therapy and in the intake interview and he tells you he has erectile dysfunction.

Let's talk about sex

Participant 9:

Yes I actually have seen someone at King Edward, I was a little overwhelmed. I think that was the most awkward. The girl was hard, but him... I think I blushed the whole time and he was probably about thirty, still young to have that problem, that was super awkward because he was so open about it... he was Muslim as well so me being female and he being so open which they aren't normally with woman.

Interviewer:

So the expectation that you had, here is this Muslim man speaking to a woman so openly?

Participant 9:

I was in Trauma [unit at the hospital] but I was given this intake and was going to pass it on. It was so long and he was very open about everything, the actual sexual intercourse, and I spoke to the interns there at the time, obviously I was going to pass the case on. They asked me if I felt he was doing this on purpose, I wasn't really sure because I didn't assume that, they asked if he was getting sexually aroused by talking to you about this stuff, but I said no because even though he was so open about it he was sweating and very nervous, it was a huge thing in his life and that's why he had eventually come for therapy. He had done everything and didn't know how or why. He had tried pills and all this stuff was not working, it was so awkward and it was because he was so open.

Interviewer:

So in the room you now were dealing with a religious expectation, a male and young again, perhaps if he had been sixty it would have been more appropriate and less awkward.

Participant 9:

As I said the older man was open but not to the extent that the younger man was he went into graphic detail.

Interviewer:

So it was uncomfortable for you.

Participant 9:

It was very uncomfortable because I was not prepared for that at all I was not expecting something like that. I ended up seeing him again because they said just stick with it, they wanted to know if he was just playing around with us. But it turned out to be an actual problem because he was referred to the clinical psychologist. It was so awkward and it think it was because he was so open with me I didn't expect that, I expected him to talk about the other stuff.

Interviewer:

But this was the reason why he was there?

Participant 9:

Yes he got straight into it, he had a girlfriend who was a lot younger than him so it was a problem for him.

Interviewer:

So again it's interesting for me, people come and tell us all the time, intimate things. I use the word intimate because it's intimate for someone to tell us how much they hate their mother, for example, that is really difficult, we seem to be able to deal with that, why do we separate these things, why is sex and sexuality such a taboo?

Participant 9:

I think it's society, it definitely plays a role in it because it's maybe how we've grown up, not to keep it a secret but not to speak about it so openly, or that could just be me.

Interviewer:

Well how were you raised?

Participant 9:

Let's talk about sex

I've got a very open family even with my sexuality it's never been a problem, my Mum my Dad. But it's not spoken about in my extended family. I live with my partner on my parents property in the granny flat at the moment, we've been together for eight/ nine years so it's a long term relationship everyone knows her. She's at every function but it's never spoken about like: this is your partner. She's just there, she's one of the family, my parents speak about it but the rest of the family don't. That's why I'm saying it's weird because my parents are open but we've never openly spoken about sex as such.

Interviewer:

So how were you educated on sex?

Participant 9:

I can't even remember.

Interviewer:

So you never had your parents sit down and discuss sex?

Participant 9:

No. My Mum told me about puberty and stuff and that was an issue for me because when I got my period for the first time it was weird and I didn't even want to tell them. And sex... she glossed over it which was weird, I don't know if that's just how they are. I think now that I'm older my Mum will make funny jokes about sex but it never was discussed, I always felt awkward about that stuff and perhaps they felt the same.

Interviewer:

But we are open about so much until it comes to sex and sexuality so that's why I'm so interested, why do we separate this? At what point does it become an unspoken thing?

Participant 9:

I think she was more open about sexuality than sexual intercourse. I think that's why I'm gay... she always said to me: it doesn't matter who you're with, if you're this, if you're that, I love you no matter what. She had gay friends and all that kind of stuff, so maybe it's her fault, there we go.

Interviewer:

I think she gave you the space to be who you are and that's awesome. Imagine if you had been raised in a home where that wasn't going to be accepted? That's interesting that sexuality was easier to speak about than an actual discussion of what sex is. So talking about sexuality, sexual health, sexual functioning, thinking about all the clients you've mentioned, what strategies did you employ to help you deal with these obstacles that you experienced?

Participant 9:

My number one was using the word intimate, no sexual activity no sexual intercourse, that was my number one to help me, it's easier to say.

Interviewer:

This is interesting because we do choose certain words, so intimacy helps you.

Participant 9:

It makes me feel more comfortable with it and also using the marital history as a gateway to speak about it. Obviously not everyone is married, the words, your relationship, as a warm up before going into sexual words.

Interviewer:

So do you think it's easier to speak to someone that you know is married than speaking to someone who's in a relationship or single?

Participant 9:

No not necessarily, it would be the same for either, maybe married people because you would assume they were having sex.

Let's talk about sex

Interviewer:

Where the married couple could be having no sex and the single person could be having a normal sexual relationship?

Participant 9:

Which is the case with me. The one case, the woman, they weren't having sex and they were married and he's not married and having sex.

Interviewer:

That's interesting because earlier you said that society, there are assumptions within society, the assumption if you're married you're having sex, is there the assumption sitting with this male, what's society's assumption? What makes it awkward for you? Is it that you don't want him to think you're coming onto him?

Participant 9:

That actually has crossed my mind before. I never come across like that at all, I think the reality of him like I said.... he could be a friend I could bump into him at work or when out.

Interviewer:

He could be your boyfriend, he would have the assumption that you're heterosexual, you both the same age, so is that also in the room, assumptions, what is he going to think if I start asking him these kind of questions?

Participant 9:

I think it boxes me in a little bit because instead of being as open as I would usually be there's the camera, all these awkward questions, so let's follow the script, you have to follow and it's impersonal, so I'm contradicting everything I've said.

Interviewer:

No not at all and again it puts this whole sexual stuff in a little box as well of not really knowing of what to do with it, is gender, society, culture, age all those things we don't quite know what to do with it.

Participant 9:

Culture has a lot to do with it for me, not that I'm racist but it's a reality, it definitely his race his age and his gender that played a role when I asked those questions, definitely.

Interviewer:

So tell me what it would be like had he been black?

Participant 9:

I don't know actually but I know maybe it would be a bit easier.

Interviewer:

And why?

Participant 9:

Maybe it wouldn't be because I also have black friends, maybe it's the male and not the race, maybe it's the age. But perhaps I would feel just as awkward even if it was an older person because I'm so young, I'm asking them about their sexual history, so it's about how I feel as to how they will feel me asking these questions, I'm this youngster asking them all these sexual questions.

Interviewer:

How about a teenager? A teenage male?

Participant 9:

I haven't experience that yet I think for me that's hard.

Interviewer:

So thinking back now what would you do differently when broaching the topic of sexual health?

Participant 9:

Let's talk about sex

Because we've been speaking so much I feel that I don't ask enough actually, I just go through it so maybe I should, I would still use the word intimate but I think I should rephrase when they ask me to clarify, tell me about your sexual activity, I never probe enough, I assume things.

Interviewer:

What do you think would have been helpful within your training to equip you to deal with sensitive topics like sexual health?

Participant 9:

I definitely probe more, I was too brief, they assume we know how to ask these questions. I think it would be nice to actually focus in on that topic and have the right questions and they need to tell us when it's appropriate, is it appropriate to ask everyone or what questions are specific to be appropriate to a specific person or a situation. Obviously we can't predict, but if we had the guidelines then when a person comes in we can say or decide this is the right question, this is the wrong question.

Interviewer:

And what about more info generally on sexual health? A topic on sexual health, what does it mean, for what age.

Participant 9:

Yes because I know the lecturer did give us a reading and it did have something to do with sexual health. We got the reading but it wasn't something we discussed in class so I do think it would be beneficial to actually discuss it in class for at least half an hour.

Participant 10

Interviewer:

We are looking at the knowledge of the interview process and the content. What was your experience when conducting your first interview with a new client so just in general, what was that experience like for you?

Participant 10:

Very nerve wracking, I didn't have the right information, how's the client going to see you... because of my age?

Interviewer:

How old are you?

Participant 10:

I'm twenty two initially the first one was hard you feel like you're not really there. The role-play was done but you don't feel like you're in it but as you get used to it, it becomes easier.

Interviewer:

Nothing can really prepare you? Did you orientate your client to the process? Did you explain to them what the intake interview was going to be like, did you do that at all?

Participant 10:

No. I had the intake form and told the client I was going to ask questions...

Interviewer:

So did you use the Morrison Intake? Did you have that in front of you and go through each thing?

Participant 10:

No. I didn't have it in my hand normally I just used it to double check. I just keep it aside and I just go with it because we have to record thankfully.

Interviewer:

Yes it makes a big difference, so do you find that comforting?

Participant 10:

Let's talk about sex

I find it comforting but I don't know about the client.

Interviewer:

Your first client, how old? Male or female?

Participant 10: It was a family it was the first time I had seen them, they seemed fine ...

Interviewer:

Did you have an understanding about gathering sensitive information like suicide ideation, alcohol abuse, medication and sexual history and sexual functioning, when you went into your initial interview did you know that these were things that you would have to ask about? And how did you feel knowing that it was on your list?

Participant 10:

Actually I didn't know I had to ask those things. But I started with sexual history but I didn't know how to ask it because both parents came with the child.

Interviewer:

How old was the child?

Participant 10:

Nine years old and just didn't ask it, I didn't know how to.

Interviewer:

So it didn't seem relevant to you case?

Participant 10:

No not to an eight or nine year old but someone brought it up that maybe it was important to always ask.

Interviewer:

It is but you don't know how to ask it? So do you think you were adequately prepared for conducting this initial interview including gathering sensitive information?

Participant 10:

No. Initially we got told we have to do an intake and even when we sit and discuss after a lecture none of us actually brought it up. We were told how to ask it but it was not discussed, so we struggled with this but being told once isn't enough. I think it would be better with someone with similar demographics as you because you would feel more comfortable asking this, but then again it's difficult.

Interviewer:

So you say even in the seminar room you feel it would be easier for you if there was someone similar to you as in male, black, would you feel more comfortable talking about sexual history and sexual functioning?

Participant 10:

No not so much in the seminar room, in therapy.

Interviewer:

So what we are talking about then are more cultural aspects? So would it be easier for you to talk to someone similar to you? If I was your client would you be able to ask me about my sexual history and sexual functioning?

Participant 10:

I would try and ask you about your sexual activity, I wouldn't know how to, I would rather not ask it but if it was a male I would feel more comfortable, I would have a fuller intake, but with anyone else it would be difficult.

Interviewer:

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And why do you think that is, if someone was similar to you, what is it? Do you feel you would relate better to them? What would make it difficult to ask me, you've never seen a white middle age woman, so what makes it easier to ask someone similar to you and not other people?

Participant 10:

Because we never talk about it, so if I see a guy they also have grown up not being told. You learn it at school but you don't speak about it at home, they understand where I'm coming from. We're friends so we would feel more comfortable talking about it but not around other people.

Interviewer:

Now what if it was a female, similar age to you, same cultural background, how would that feel for you? Difficult?

Participant 10:

It would depend on the problem she came in for. I would try and probe and ask questions around it, indirectly it's not something I feel comfortable with asking directly. Sexual history is something I feel very uncomfortable speaking about it.

Interviewer:

When you were younger and in your home it wasn't a topic of discussion, so your parents didn't sit down and tell you about sex?

Participant 10:

No. The entire family. Parents do not speak about sex.

Interviewer:

So how did you find out about sex, who tells you in your family?

Participant 10:

Now my mum feels comfortable talking about it: do not have sex do not do this and that, in the home but besides that people do not talk about it. I learnt a lot through school.

Interviewer:

Through your friends or teachers?

Participant 10:

Through teachers and friends, but when you get home you don't speak about it, but we do now since I've got older, eighteen, nineteen she's a lot more comfortable with it but not anywhere else, if I have a girlfriend how do I speak about those things?

Interviewer:

What if you had a question you needed to have answered, who did you go to? To your friends?

Participant 10:

My brother or my friends.

Interviewer:

Definitely not your mum?

Participant 10:

No not my mum.

Interviewer:

So if you think that there's a familiarity with the process, if we go into intake interview, what are your own personal challenges having to actually ask about sexual functioning and sexual history? For you what is personally challenging when asking that?

Participant 10:

Because you grow up being told not to speak about that, you just don't speak about it, it's cultural. When you speak about it people perceive you as being forward so even in therapy I sit there and think

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they will perceive me as being forward and perhaps never come back so it's one of the questions I keep aside and if my supervisor tells me to ask it then I will ask it but if not I just go past it.

Interviewer:

That's really interesting that you say that because there is this societal understanding that you just don't speak about it and if you do you're forward, you're coming onto somebody? You wonder what they think of you? Yet sex is around us all the time, if you think of the media it's in our faces all the time, nudity, sexuality but we mustn't talk about it, it's a bit odd isn't it? You can ask about other thoughts, you can ask about killing yourself which is quite a personal intimate thing but when we get to sex we don't want to ask?

Interviewer:

So do you think that you understand why you need to ask about sexual functioning and sexual history.

Participant 10:

Yes I do understand, it's important because if someone has been in an abusive relationship, sexually assaulted, molested, it will play a big part in making have an impact on the person which could lead to frustrations it could be linked to that and expressing their emotions it could be a lot of things every question plays a role. It's just how to ask the question not that it's not important, even though it's important you don't know how to ask it.

Interviewer:

You don't know how to get the information and also maybe a deeper understanding of why I'm asking this and if I understand why I'm asking there might be easier ways to get there. So on this piece of paper it just says sexual history and sexual functioning, but why? There no lectures about sexual health or sexual functioning and why this is important what it's linked to, would that make it different for you? Would it give you better understanding?

Participant 10:

I think it has a lot to do with confidence. You know someone's coming, we did have role-plays on how to ask it in a particular way. If someone comes in you can't just say: tell me about your sexual history. They would look at you and say 'what do you mean' and then you don't know what to say after that.

Interviewer:

I think also in the orientation process it might be helpful to say to your client that you might ask questions that maybe a bit uncomfortable, is that ok, but I'm just trying to gather a full history, to orientate your client, to normalise it, because most of the time it's not normal conversation but we can ask about everything else! If you consider that when somebody is in therapy with you it's already and intimate relationship because they share a lot with you that they wouldn't say to anybody else not just about sexual history and sexual functioning and we feel comfortable with that but we don't feel comfortable with sexual history, sexual functioning.

Interviewer:

So in that moment, obviously your case is a little different because you had an assessment and you were doing an intake with the parents but tell me about that discomfort that you felt when you knew you were going to ask this, what did you do? Did you quickly brush it off and move on?

Participant 10:

Yes very quickly, even when I picked the paper up afterwards I felt ok it's done, if my supervisors ask this then I'll go back.

Interviewer:

Your client... do you think you would be able to ask, if you needed to? Would it have been easier to ask the husband or the wife? Were they from a different cultural background to you, what were the things that would affect your asking those questions?

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Participant 10:

I think it's a language barrier, we speak in English, we know what to ask in English, we're taught to ask in English.

Interviewer:

So were you conducting this interview in Zulu?

Participant 10:

Yes in Zulu, you do not know how to ask in Zulu it will never sound the same, Zulu is much deeper, so I was thinking how do I ask this.

Interviewer:

I would really like to know about this as you are the first person to bring language into this, very interesting for me. So in Zulu, you said it's much deeper.

Participant 10:

In English there are so many indirect ways of putting it, in Zulu it's direct and it's just going to sound so bad.

Interviewer:

In the Zulu culture is it a taboo subject to speak about?

Participant 10:

Yes it is taboo because there's always this difference in power, they were elders/adults and I was never going to ask this, to someone my own age I could ask it, not to a child because they would tell this to their parents and they would wonder why I asked this, because they don't speak about this, so I'm assuming this is how they grew up in our culture, so if I had to ask it in Zulu it would be new to them, why is this guy asking this, what's he trying to do and then they wouldn't come back to me so if there was a way of putting it lightly, maybe, I'm not saying I would.

Interviewer:

So what you saying is that the Zulu language makes it more difficult for you. Some of my other participants that they've been using words like intimate, so is there an equivalent in Zulu?

Participant 10:

No, there are some words that you just can't use, so if you have to translate.....

Interviewer:

So in Zulu you are talking about sex.

Participant 10:

That's it, have you every slept with a guy or have you had sex, it's the same thing.

Interviewer:

Plus you've then got the power ratio that makes it more difficult as well.

Participant 10:

It's just too much... you can't, you're just not brought up right, they would disapprove of me. Then it would be said that it was the psychology that did this to me, there are so many levels because what you're doing is so wrong, so just to keep the relationship good and strong I don't ask it.

Interviewer:

So what happens now if you're asked to take an adolescent let's say a fifteen or sixteen year old, also same culture as you, in our field it's quite different, we can maybe feel that they not engaging in but a teenager, you're now doing an intake of the parents of a teenager, does that change for you that you really need to ask about this or do you leave or do you leave it until you're with your adolescent client and then would you be able to speak to you adolescent client?

Participant 10:

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It's tricky,it might just anger them if you asked that because you might put ideas into the child's head. In English I would have to think about it, knowing me I probably wouldn't ask, now that you've brought it up I will ask my supervisor.

Interviewer:

And to understand why we're asking, it's on our piece of paper that we have to ask that then how do we do that?

Participant 10:

You must find ways to ask that, probe into it, going into a deeper level probing.

Interviewer:

So we need to know what we're probing for, why are we asking this exactly, we get a seminar on suicide, I think three actually, we do alcohol abuse, we do drug abuse, there isn't a little slot for discussing sexuality, sexual health, whatever you want to call it, under the umbrella of why do we need to understand this? Why is it on this piece of paper? Because clearly it's important, it's my personal opinion, I don't feel there's enough support why we ask this.

Participant 10:

This is true, we try... everyone tries, we spend hours... bring up something. We always have guest speakers coming in... we learn so much throughout the entire year, we're starting now we need that foundation.

Interviewer:

What do you do when a man sits in front of you, no let's make it more complicated, a woman sits in front of you and she says she has a problem, she can't have sex because her vagina closes every time she has sex, what if this happens that she says this to you? How are you going to deal with this? I've asked my female participants, what if a man sits in front of you and says he has erectile dysfunction, these are things we need to think about and understand sexuality, sexual functioning, sexual history, find a way to normalise it and not always make it so outside the box.

So if we think of in relation to the effects of culture, gender, language differences, what we've just spoken about what for you are the biggest struggles and difficulties, is it gender, culture, religion, language, what do you immediately think of?

Participant 10:

Language and gender, it's not age, you don't need to be old to understand it.

Interviewer:

So for you it's language and gender?

Participant 10:

Yes we need to feel comfortable with the language, it's important to feel comfortable to say something but there again it does damage if you ...

Interviewer:

Which you don't want to do. So why do you think it would be more uncomfortable for a female to talk to you about it than a male?

Participant 10:

Well sexual history, that's fine but let's say it's sexual abuse, more often than not they've been abused by a male, they over protective, they just shut down. So you're going nowhere very quickly I think that would be difficult, if it was a younger female it would be more tricky because the parents are there she won't speak ...

Interviewer:

But the interesting thing is that if you....so conversely if you had a female client that had been sexually abused by a male a lot of healing could happen during therapy with you being a male who is accepting,

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non-judgemental, empathetic. So almost in a way re-teach her that men can be kind, considerate, compassionate, do you understand what I'm saying? So again that's an interesting way of challenging our stereotypical way of thinking. Because you immediately think you don't want to re-traumatise her, but in actual fact, not always, it can be a very beneficial thing for that female to learn that this is a good relationship. How do you think these aspects, let's look specifically at language and gender influence the client's disclosure to you? I know you haven't actually asked about it because of the context of yours but do you think these aspects would influence whether they would disclose to you or not when you ask them about sexual history and sexual functioning?

Participant 10:

It depends on the client, some clients are comfortable to speak about it some clients are not, I think it's more something I need to deal with than the clients. If the client wants to speak about anything, irrespective of those aspects, they will speak about it even if there's a difference in age, gender, they have to trust you otherwise they just shut down.

Interviewer:

So you think it's got more to do with us as clinicians as how we are in therapy, of whether a client is comfortable to disclose or not?

Participant 10:

... and work through that even though we are trainees, growing we are still developing. A lecturer once said to us: don't try and break the ice when there isn't any. Like language barrier, like words in Zulu ... I feel I can't speak to them because of certain reasons.

Interviewer:

But that might not be the issue?

Participant 10:

Exactly, but just try it, if it doesn't work then it doesn't work, so as you say we need to train more and try it, and see what happens.

Interviewer:

And more practice. Just for interest, how were your role-plays in your group, did you actually ask around sensitive topics, like suicide and sexual history?

Participant 10:

Suicide we asked about it, sexual history we asked but had a good laugh about it because people, we were very close within a week or two, it would have been better if we were allocated to different people where you have someone you're not so comfortable with then you pick up that it's hard to ask those questions. So in our role-plays we had a good laugh we didn't take that question seriously, so now it's catching up with us.

Interviewer:

No, not really I think it's the same for everybody so don't be too hard on yourself. Everyone has the same experience this is why I'm so interested in it. During my role-plays last year, this is what alerted me that this was very interesting. I'm married, I've got children so for me talking about sexual history, sexual functioning, it's a lot easier, so that's why I was with a lot of people that were younger, some were married some were not, that's interesting why is it easier for some people to talk about it and others not. So if we're thinking about asking about sexual functioning and sexual history what are some of the things that assist or hinder your questioning around sexual health, conflicting value systems, invasion of privacy? What are some of the things that you immediately think of when you know you have to ask around this?

Participant 10:

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... a particular alliance I try and build that, patience, I try my best to do that ...once I know a person's comfortable about something once I know that then I can speak about it.

Interviewer:

So if you look at the therapeutic alliance, the working alliance, you are concerned that in the initial intake interview that this might risk that? So do you think it would be easier to do it in the third or fourth session, if it hadn't come up do you feel that if you built up this alliance it would be easier to bring the subject up?

Participant 10:

Yes I think that's why I always stall the question. I know I'm scared I do everything else until the supervisor says you need to ask this question now but again the client must trust me, the client must be strong.

Interviewer:

So it sounds like you almost saying then that there needs to be trust before you can talk about anything regarding sexuality, did I understand that correctly?

Participant 10:

Yes there has to be a sense of trust and comfort they can then speak to me, they don't judge me they don't perceive me as anything different, but until you've reached that point it's very hard, there are risks.

Interviewer:

So again it seems that anything to do with sexuality you feel quite hesitant of bringing it up, you don't want to lose the person's trust, you feel you have to be very careful around this topic?

So what were your expectations of when you had to cover this sensitive topic? What did you go in thinking about knowing that you had to ask about sexual health and sexual history?

Participant 10:

Looking at the list was fine but that question was like red! You're prepared for every other question except that one, everything just falls flat.

Interviewer:

So your expectation was that this was going to be challenging?

Participant 10:

Yes very challenging.

Interviewer:

So it sounds like when you're weighing up the risk it's not worth it.

Participant 10:

No, for me the risk outweighs the benefits, for me, so no just put it aside.

Interviewer:

I wonder if it's linked to, do we have an understanding of why we're asking this.

Participant 10:

Could be, the more you understand about something the more comfortable you feel about it. Like I said it's more an issue we have about asking the question than the client has, so if we can get the training and the assistance we would be more confident.

Interviewer:

Yes, we get trained in suicide, we have an understanding of why we're asking it, what we should be looking out for, what is it linked to, so that we're quite clear about but we're not pointed in the direction of, we're looking at sexual history and sexual functioning because it's about this, this and this, it's just as you say 'red'.

Participant 10:

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Yes if you look at the criteria about suicide it says 'suicide ideation' so suicide is important, sexually we know it's important but we're not too sure why.

Interviewer:

So you said that there was anxiety around it, rushed and overlooked.

Participant 10:

It was if it wasn't there.

Interviewer:

Almost everyone said the same thing and yet there it is on the intake, isn't it?

So what would you do differently when approaching this topic on sexual health?

Participant 10:

I would do it myself, your family the context that has a lot of bearing on it, some people ask the question freely, even though we are all in the same group some are more comfortable than others.

Interviewer:

So maybe familiarising ourselves with this topic of sexual health so it's not so daunting and in your face and you don't know what to do with it, because it seems like conversations around sexual health they're not normalised they're not everyday conversations, but as I say it's so contradictory because it's in our face everywhere, media, music etc?

Participant 10:

Yes, friends speak about cars, we'll speak about suicide, hospital but sex everyone suddenly turns their heads in surprise, so you know what society create.

Interviewer:

As you say all of us are in and out of relationships so must of us are in some kind of sexual activity at some time of our lives but nobody is talking about it, odd.

Participant 10:

Yes it is society, once I speak about it people will judge me, I will be judged.

Interviewer:

So sex and judgement, there seems to be a lot linked to that? So what do you think would have been helpful in your training to equip you with dealing with sensitive topics such as sexual health?

Participant 10:

Orientation, more orientation to deal with these challenges, we did a lot of videos we did a lot of reflection, even now all is not lost we just need assistance again, even a three hour lecture because right now we're there but we're not there. We know that questions must be asked but just now how to and why, so we need a seminar, at least a seminar.

Interviewer:

Sharing your knowledge of how and why and discussion that's also something you can generator with in your masters class, you've got such a nice demographic a good range of culture and religions so potentially to have a class discussion.

Participant 11

This was not recoded due to malfunctioning recording equipment. This was taken from the notes made during the interview.

Participant 11:

I am comfortable with my own sexuality. However I was not told about sex at all and I don't think that is a good thing. I think children need to be told properly, what the actual act is, the consequences, the risk. I was an example of that - I had my first sexual experience and I fell pregnant. If I had been properly

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educated I may have been more careful of the choices I made. But you know, all your friends are doing it, experimenting and well.....you just do things without really knowing.

Participant 11:

I ask it like it is just another thing on the list to get through. I don't have a problem with it. My client was ok - he was younger. I think if he was older it would have been more uncomfortable. It is easier with a woman to talk about sex.

With a manyou don't want to feel like you are crossing boundaries.....

Interviewer:

What are you afraid of? concerned about?

Participant 11:

Mmmmm asking things that are not going to be offensive

Interviewer:

Yet asking around other sensitive topics is not offensive? Does not hold the same energy as talking about sexual issues?

Participant 11:

No I guess not

Interviewer:

Can you say more about the discomfort about the man who was paralysed?

Participant 11:

I felt so sorry for him, I was so uncomfortable to see him there....you know - not being , or able to....have sex. I almost thought for a second...it would have been better if it had been a woman

Interviewer:

What was it that made you uncomfortable?

Participant 11:

I don't know....it's weird, but as a man.....you know men, have girlfriends.....I can't believe I am actually saying this.....but

Interviewer:

Do you feel that it would not be as bad for a woman? Looking at a woman lying there....you would not have thought "shame she won't be able to have sex"?

Participant 11:

No.....I don't know why but a man.....

Interviewer:

A man needs to have sex to be a 'man'?

Participant 11:

Yes I guess

A man equals a penis which equals sex

Woman ignore it.....hope it will go away

Interviewer:

Do u think as female therapists we then don't pay enough attention to men as sexual beings and we perpetuate the idea that men equal sex and that woman not sexual?

Participant 11:

Yes