Clinical psychologists’ views about talking to people with psychosis about sexuality and intimacy: A Q-methodological study

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Keywords: Intimate relationships; sexual need; psychosis; mental health; discussing sexuality

**Abstract**

Sexual and relationship needs of people with psychosis are generally overlooked despite established psychosocial benefits and reduced risk of relapse. Despite mental health professionals’ reluctance to initiate conversations about sexuality and intimacy with service-users, people with psychosis and their support networks have indicated their desire for professionals to address intimate topics. Clinical psychologists are specifically trained to address complex psychological issues; however, no research to date has explored their views around discussing sexuality and intimacy. Q-methodology was used to explore clinical psychologists’ personal and professional views about discussing sexuality and intimacy with people with psychosis. 27 clinical psychologists completed Q-sorts. Varimax rotation revealed three factors with distinct views; a majority perspective that highlighted the normality of sexuality and intimacy for people with psychosis and the acceptability of such conversations in clinical work for practitioners, a view focused on concerns about the appropriateness of discussing sexuality and the possibility that conversations could lead to increased risk, and a view that related to concerns about competency in addressing intimate subjects. The practical and clinical implications are discussed in terms of training need and limited access to sexual health services.

Keywords: Intimate relationships; sexual need; psychosis; mental health; discussing sexuality; psychological assessment

**Introduction**

Sexuality and intimacy can be defined as the opportunity to explore access to satisfying intimate relationships (de Jager & McCann, 2017) and engage in sexual expression, eroticism and pleasure (Gascoyne, Hughes, McCann, & Quinn, 2016; WHO, 2015). Intimate relationships are crucial to individual quality of life (Tierney, 2008). Policymakers argue that the population should be free to make relationship choices without stigma or prejudice, regardless of disability or illness (Department of Health, 2013). Sexual health policy states that from a human rights perspective, every individual is entitled to access to information and services that promote sexual health (WHO, 2015). However, the sexual and intimate relationship needs of service-users are rarely addressed in mental health services (McCann, 2010a).

Sexuality, intimate relationships and mental health has only recently become an area of interest for researchers (Gascoyne, Hughes, McCann, & Quinn, 2016). Some research has explored more common mental health difficulties and sexual and relationship challenges, such as the impact of depression on couple interactions (Sharabi, Delaney, & Knobloch, 2016) and sexual dysfunction as a result of anxiety in women (van Minnen & Kampman, 2000). By comparison, the sexual and relationship opportunities for people with psychosis has been overlooked (Kelly & Conley, 2004; Östman & Bjorkman, 2013). Only recently has it emerged that there may be significant barriers to relationships, sexuality and intimacy for individuals with psychosis (Boucher, Groleau, & Whitley, 2016).

Stigma and prejudice increase the risk that the relationship needs of people with psychosis are marginalised (McCann, 2003), as stereotypes portray individuals with mental health difficulties as engaged in risky or deviant sexual behaviour (Buckley, Robben, Friedman, & Hyde, 1999). Those experiencing psychosis have often survived sexual abuse or trauma, and the emotional consequences of these experiences can prevent people from accessing support (McCann, 2010b). The personal burden of low self-confidence, low self-esteem and lack of self-care often reduce the likelihood that they will seek help with sexual issues (Quinn & Happell, 2012b).

Anti-psychotic medications are often prescribed as a first-line treatment for psychosis (National Institute for Health and Care Excellence [NICE], 2014) and can provide relief from distressing symptoms (e.g. Leucht, Corves, Arbter, Engel, & Davis, 2009). However, such medication has well-documented adverse physiological side-effects that affect sexual functioning (Baggaley, 2008). Such experiences can be psychologically traumatising, negatively affecting one’s self-image (Southall, 2017), yet mental health professionals rarely assess this impact with service-users (Gascoyne, Hughes, McCann, & Quinn, 2016).

Evidence for the effectiveness of dominant psychological treatments for psychosis is mixed (Goldsmith, Lewis, Dunn, & Bentall, 2015; Jauhar et al., 2014; Pinquart, Oslejek, & Teubert, 2016; Taylor & Perera, 2015). In addition to traditional treatments such as cognitive-behavioural therapy and medication, NICE guidelines recommend person-centred care packages and a focus on recovery approaches that include social rehabilitation (NICE, 2014). Recovery approaches encourage service-users to take responsibility for their own mental health and conceptualises the process of overcoming mental health difficulties as a journey incorporating a variety of principles that guides the support offered by mental health professionals (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011).   
  
Restorative elements of the recovery journey include close personal relationships (Davidson et al., 2007; Drake & Whitley, 2014; Soundy et al., 2015; Tew et al., 2012). Social support can promote psychological wellbeing (Pruessner, Iyer, Faridi, Joober, & Malla, 2011) and predict better long-term outcomes for those living with the condition (Tew et al., 2012), with intimate relationships acting as a buffer against the psychological stress of coping with psychosis (Gayer-Anderson & Morgan, 2013).   
  
Mental health services have yet to demonstrate how they can support people with unmet social needs that are central to recovery (Hughes, Edmondson, Onyekwe, Quinn, & Nolan, 2018). People with psychosis are often unable to access social networks and support in developing intimate relationships (Gascoyne, Hughes, McCann, & Quinn, 2016; Östman & Bjorkman, 2013; Pillay, Lecomte, & Abdel-Baki, 2016). Paradoxically, psychosocial factors such as independent living, social contact and being in a relationship significantly predict recovery from psychosis (Albert et al., 2011; Onken, Craig, Ridgway, Ralph, & Cook, 2007). Recent meta-analyses have suggested that interventions aimed at supporting people with psychosis in developing social skills may promote quality of life and produce positive outcomes in terms of reduced relapse and rehospitalisation (Almerie et al., 2015).

People with psychosis highlight sex and intimacy as a key area of need - as important as physical health and housing (Fleury, Grenier, Bamvita, & Tremblay, 2012). For many, it is actually closeness and intimacy that is rated as the most important aspect of relationships over and above sexual contact (Southall, 2017). Sexual expression and intimate relationships are also reported as an area of concern by family members (Iyer, Loohuis, Pawliuk, Joober, & Malla, 2011) and mental health staff (Hensel, Banayan, Cheng, Langley, & Dewa, 2016). Crucially, service-users have expressed their desire to discuss sexuality and intimacy, looking to mental health professionals to open conversations (McCann, 2000).

Reluctance to discuss sexuality and intimacy amongst health professionals is clearly an issue that requires investigation (Dyer & das Nair, 2013; McCann, 2003; Miller & Byers, 2012). Reasons for avoiding discussions around sexuality with service-users include beliefs that sexuality is “not important” and that talking about sexuality is “not part of their role” (Quinn, Happell, & Browne 2011). Healthcare professionals may also avoid the topic because of concerns about their proficiency in dealing with the subject matter, time constraints or embarrassment and personal discomfort (Dyer & das Nair, 2013). Resources have been developed to support healthcare professionals in opening dialogues on sexuality with service-users (Butler, O’Donovan, & Shaw, 2010; Mick, Hughes, & Cohen, 2004; Quinn & Happell, 2012a). However, practitioners may still consider sexuality as an area outside of their skillset and defer to a clinical psychologist for guidance and consult (Miller & Byers, 2012).

Clinical psychologists may be well-placed to explore issues of sexuality; in the United Kingdom (UK) training programmes incorporate teaching of advanced communication skills and techniques in competent and effective assessment, formulation and intervention (British Psychological Society, 2014; Division of Clinical Psychology, 1995). Skills should extend to exploring complex issues and needs with people with severe mental health difficulties (Division of Clinical Psychology, 2010; Onyett, 2007). Despite the focus on high level skills, reluctance to address sexuality and intimacy amongst clinical psychologists may be linked to lack of training (Miller & Byers, 2010; Reissing & di Giulio, 2010) or concerns about competency (Miller & Byers, 2012), particularly for those who have recently qualified (Sanger & Persson, 2014).

Whilst recent research has explored the challenges of discussing sexual issues from a nursing perspective in the UK (e.g. Gascoyne, Hughes, McCann, & Quinn, 2016) and in Australia (Quinn & Happell, 2012b), little is known about the views and attitudes of clinical psychologists trained in the UK around discussing issues of sexuality and intimacy with people with psychosis. Developing on recent research into the role of mental health professionals in discussing the sexual and intimate relationship needs of people with psychosis, the present exploratory study uses Q-methodology to explore UK-based clinical psychologists’ views on discussing issues of sexuality and intimacy with people who experience psychosis.

**Method**

***Overview of Q methodology***

Q-methodology is a unique ‘qualiquantilogical’ methodology combining both traditional quantitative factor analysis with the qualitative study of perspectives (Watts & Stenner, 2005). Developed by psychologist William Stephenson (Stephenson, 1935) Q is used to study subjectivity – the diversity of attitudes, opinions and viewpoints on a particular topic (e.g. Brown, 1993). Although Q was originally developed as a psychological research method, it has since been extended across political, education and health research (Brown, 1980; Cross, 2005). Participants are asked to order a set of statements (the Q set) according to their own viewpoint within a pre-determined distribution grid. Because the distribution only allows participants to assign a certain number of statements to a given rating e.g. from Most Disagree (-6) to Most Agree (+6), the pattern is one of a ‘forced’ rather than ‘free’ distribution. Factor analysis then enables correlation of each participant’s Q-sort, thus representing an inversion of conventional factor analysis wherein correlations between test items are explored (Watts & Stenner, 2012).   
  
Q-methodology was developed to essentially explore ‘segments of subjectivity’ (Brown, 1993). Q is rooted in the qualitative tradition but differs from other approaches because it does not seek to reduce data to themes, and purely aims to explore the diversity of opinion and attitude (Cross, 2005). Q stands as a robust method in that it allows participants to apply their own meaning to the materials and provide their subjective perspective on the subject matter (van Exel & de Graaf, 2005). In addition, Q is a versatile methodology when exploring diverse groups of viewpoints on complex, sensitive or challenging subject matter (Watts & Stenner, 2005), and it has been used to explore other issues in mental health and clinical psychology (e.g. Dudley, Siitarinen, James, & Dodgson, 2009; Lister & Gardner, 2006; Meredith & Baker, 2007). Although a discussion of the history and methodology is beyond the scope of this article, there are many thorough introductory pieces on Q-methodology (e.g. Brown, 1993; Watts & Stenner, 2005; 2012).

***Development of the Q set***

A rigorously developed Q-set should be a broad representation of views around a given subject (Watts & Stenner, 2005). A Q-set of between 40 and 80 statements is considered appropriate (Eccleston, Williams, & Stainton Rogers, 1997). The statement concourse was developed by reviewing a diverse range of literature, including books and articles on psychosis and schizophrenia, sexuality and intimacy, recovery, psychosocial needs of people with severe mental health difficulties, clinical psychology practices and training, stigma, and health professionals’ attitudes to talking about sexuality.

Five psychologists known to the researcher (four clinical psychologists and one counselling psychologist) from a range of different settings representing a diversity of professional experience were invited by email to contribute ten items to the Q-set. Duration of experience as qualified psychologists ranged from less than one year post-qualification to twenty-six years’ experience. Each psychologist was sent an email describing the research question, a description of Q methodology and an invitation to suggest ten statements relating to the subject area.

Statements were reviewed by a Q-methodology research interest group comprising trainee clinical psychologists and a senior lecturer. Two further consults on the statements were made by a service-user with lived experience of psychosis and a Consultant Clinical Psychologist with significant experience of working with adults with psychosis. The final concourse of 66 statements is shown in Table 1.

Table 1 Table of statements about here please

***Ethical approval***

This study was subject to ethical approval by Staffordshire University Research Ethics Committee. R&D approval was granted by two NHS trusts in the West Midlands.   
  
  
***Participants***  
Q-methodology inverts traditional factor analysis such that participants, rather than test items, represent the variables. For this reason, smaller groups of participants are often encouraged to aid analysis and provide richness of interpretation (Watts & Stenner, 2005; 2012). A sample size of participants that is *fewer* than the number of items in the Q-set is recommended (Watts & Stenner, 2012).

A total of 27 clinical psychologists working with people with psychosis were recruited directly by email or by participants who had taken part in the study. A recruitment advert was also placed for one issue of the British Psychological Society monthly publication *The Psychologist.*Eight participants provided data in the form of physical Q-sorts (Q-sort data provided by participants), and the remaining 19 were collected using the POETQ online system (Jeffares & Dickinson, 2012). Participant demographics are detailed in Table 2. Inclusion criteria required all participants to be qualified clinical psychologists working in the NHS in England with people with psychosis in either a community or inpatient setting.

Table 2 Participant table about here please

***Procedure***

*Physical Q-sorts.* Each participant was provided with a printed A4 sheet showing the sorting instructions and the shuffled Q-set statements printed on laminated cards approximately 8cm x 5cm. Participants were asked to read each statement and form three separate piles representing ‘Agree’ “Disagree’ or ‘Neutral/Indifferent’ responses to each. At the point of completion, participants were introduced to the distribution grid which consisted of a 13-point scale from -6, representing the response ‘Most Disagree’ to +6 representing ‘Most Agree’ (Figure 1). Participants were invited to provide verbal feedback during the Q-sort and were interviewed briefly after the study was complete to provide further feedback.

*Online Q-sorts.* The procedure for online Q-sorts remained as close as possible to the procedure for physical Q-sorts. Each participant taking part in the online Q-sort was presented with a screen describing the research and providing the condition of instruction. The sorting approach employed in POETQ differed slightly to the instructions provided to participants during physical Q-sorts, specifically at the thinning stage which requires participants to systematically rank statements in terms of lesser agreement or disagreement until all cards are placed.

Figure 1 Q distribution table about here please

**Results**

***Analysis***

Data from 27 completed Q-sorts were analysed using the dedicated Q analysis package PQMethod (Schmolck, 2014). The analysis process seeks to identify correlations between Q-sorts, and factor analysis provides a statistical analysis of Q-sorts with the highest intercorrelations. Each factor is a statistical grouping of participants that have arranged Q-sorts in similar ways, thus representing a shared viewpoint within a subgroup of participants.

Factors were extracted using centroid factor analysis, the recommended and most accessible method of factor extraction (Watts & Stenner, 2005; 2012). Varimax rotation was used. Applying the Kaiser-Guttman principle of accepting only factors with Eigenvalues greater than 1.00 (Brown, 1980), three factors were extracted accounting for 76% of the study variance. All factors contained more than one significantly loading factor at a level of p < .01. Rotated factors are shown in Table 3.

Q-sorts were selected and ‘flagged’ for inclusion in each factor. PQMethod provides an option for representative Q-sorts to be automatically selected based on two criteria: that the loading is significantly high (*p* < .05), and that the squared loading is higher than the sum of the square loadings for all other factors (Brown, 1980; Zabala & Pascual, 2016). Although in this case automatic flagging was used, Q-sorts can also be manually flagged by determining high loading cases that do not confound with other factors (Watts & Stenner, 2012).

Table 3 Rotated factor loadings table about here please

***Arrangement of factor arrays***

Straightforward interpretation of each factor is facilitated by listing the arrangement of statement rankings within each factor to create factor arrays. The factor array is produced by weighting Q-sorts that load significantly on each factor. Individual rankings of statements can be used to produce exemplifying Q-sorts. 23 of the 27 Q-sorts loaded significantly onto factors. Confounding or non-significant Q-sorts were excluded from factor arrays. Statements that were statistically significant by 3 standard deviations were classed as distinguishing between other items at *p* <.01 (Brown, 1980) and were given priority in the factor arrays followed by those with a significance level at *p* < .05. Consensus statements were excluded from factor interpretations.

***Factor interpretations***

Factor arrays are a relatively accessible depiction of item rankings of items and the statistical significance of items within each factor. However, further strategies can be adopted to facilitate a more detailed interpretation of the viewpoint. The development of ‘crib sheets’ allows the researcher to systematically explore the context of each factor whilst maintaining a holistic view of the factor (Watts & Stenner, 2012). The crib sheet includes the statements at the highest and lowest rankings in the array, thus items at +6, +5, -6 and -5 were included. In addition, a further process involves listing *items ranked higher* and *items ranked lower* for that factor. Additional items can be added to the interpretation as it evolves.

***Findings***

Descriptions of each factor are provided in narrative form with the corresponding statement number and its ranking within the factor (e.g. 17, +5) to show the significance of each item and the viewpoint it represents (Watts & Stenner, 2005). Qualitative comments provided by participants are included within the narrative to provide further depth.

Table 4 Participant demographics for each factor about here please

*Factor A: The sexual and relationship needs of people with psychosis are the same as everyone else’s, and it is our duty to talk about them*

Factor A had an eigenvalue of 9.45 and explained 35% of the study variance. Participant demographics are shown in Table 4.

A distinguishing positive statement for this account indicated that participants rated the importance of sexual expression highly in the lives of people with psychosis (21, +6). This perspective was supported by views that not exploring relationships with people with psychosis ‘*would be bizarre’* (Participant 15). Many participants expressed how strongly they felt that it is clinical psychologists’ duty to address such a fundamental human issue that *‘can so easily be overlooked’* (Participant 7). Participant 17 highlighted the *‘need to acknowledge the relevance and importance of sex and intimacy in people’s lives. We can’t pretend it doesn’t exist’.*

It was important for these participants to open conversations about sex and intimacy in clinical settings because they recognise the link between intimate relationships and people’s identity (59, +6). As Participant 10 stated, conversations about sex and intimacy *‘play a crucial role in how people live and manage relationships effectively’.* Supporting statements suggested that sex and intimacy would not be avoided with clients, and that it would be an acceptable topic to address in a therapeutic setting (47, +4). Participant 15 highlighted that *‘In order for therapy to be effective we ought not to occlude any areas of normal human life, including sex and intimacy’.* Furthermore, although these participants cover many important topics with their clients, they also would not avoid conversations that focused on more intimate needs (2, -1).

Participants endorsed the belief that discussions around sex and intimacy should be acceptable in therapeutic work (35, +4); participant 2 supported this with a statement that disclosures of a sexual nature that a client finds emotionally difficult to talk about *‘can enable truly therapeutic work to happen’.* The therapeutic process involved in engaging in discussions about sex and intimacy may be facilitated by the opportunity to normalise clients’ needs and desires (38, +5).Participants also recognised that discussions about sex and intimacy can help achieve many of the core goals of therapy, specifically promoting trust and developing the therapeutic relationship (20, +1; 61, +2), facilitating greater social support for the client (22, +2) and engaging in work to reduce the likelihood of relapse (23, +2).

For these participants, an understanding of the relationship needs and perceived barriers for their clients was an important part of conducting a thorough assessment (36, +4). Such conversations should not be avoided, or clinical psychologists may miss opportunities to explore issues relating to a client’s experience that have contributed to current difficulties (37, +2). The likelihood that these participants would initiate conversations about sexuality with clients was neither decreased or increased by whether or not clients were currently in a relationship (8, 0).

There were no concerns about the perceived competency of these participants in relation to raising discussions around the sexual and intimate relationship needs of people with psychosis (43, -5), and although it could be perceived as a sensitive topic it could be addressed with the client (29, +1). Participants felt that the skills and training they already had were sufficient to ensure a comfortable discussion with clients (40, -4), and that doctoral training should provide clinical psychologists *‘with the ability to talk about every subject relevant to human experience. Sex is just another aspect of human experience’* (Participant 11). Concerns that sexuality and intimacy is an uncomfortable topic for clinical psychologists to discuss were minimal (42, -3).

Participants recognised that there were inherent risks in opening conversations about sex and intimacy, but this did not mean that there was a sense that this risk was a reason to avoid the topic (63, 0). These participants were aware that there is a level of complexity in raising topics of such a sensitive nature with clients with psychosis, but any challenges around this could be managed (41, -3) as it is the role of the clinician to explore and manage complex issues (Participant 11).

*Summary of Factor A*

Participants in this account strongly believed that it was their role to ask clients with psychosis about sexual and intimate relationship needs. This was supported by perspectives that sexuality is a human issue, fundamental to human functioning, playing a role in how people live their day-to-day lives. The role of sexuality and intimacy could play a central role in clinical work for these participants alongside other therapeutic issues. Recognising the relationship needs of their clients allows these participants to develop a thorough understanding of their clients. Conversations about sexuality and intimacy facilitated by these clinicians appear to promote the therapeutic relationship and allow the client to work through emotionally difficult issues in terms of intimate relationships.  
 *Factor B: I would talk to people with psychosis about sex and intimacy, being mindful of the possible risks and concerns*

Factor B has an eigenvalue of 6.48 and explains 24% of the study variance. This factor emphasised participants’ concerns around the appropriateness of engaging in discussions about sex and intimacy with clients with psychosis. Participants contributing to this factor were mindful that a conversation about sex and intimacy might be an important factor within their clinical work, but where there was a requirement to assess the potential issues rather than to explore needs and desires (1, +6), as Participant 4 stated *‘I’d need to if it was part of the client’s difficulties or increased their risk profile in some way’.* For this reason, it was not considered necessary to engage in a conversation about sex and intimacy, as acceptable clinical work could be undertaken without such a conversation taking place (36, -3). Participants were ambivalent about talking about sex and intimacy, and although they would not discourage or avoid a conversation about sex and intimacy, they would not initiate this if it was not deemed necessary for their work with that client (48, 0).

Concerns about the appropriateness of initiating conversations about sex and intimacy in clinical settings were clear, and this was supported by views that assessment and intervention may not include such a conversation if the focus was on more important issues (2, +3). Participants were aware that a conversation about sex and intimacy might not be appropriate for various contextual reasons (28, +5), as Participant 9 stated *“...it can be seen as inappropriate or not something you should talk about with people you don’t know…”.* This view was echoed by a concurrent perspective that people with psychosis may not want a clinical psychologist to initiate such a conversation (16, +5). These participants would decide on whether to raise conversations about sex and intimacy with a client based on background information relating to each client; contextual factors relating to the specific needs and difficulties of a client seemed to determine the likelihood of whether a conversation about sex and intimacy would occur in a clinical setting. Risk management was a principal concern for these participants. There was an awareness that discussing intimate topics may increase the risk of harm to the client themselves or to others (66, +4). Participants were also concerned about the potential for clients’ risks to increase, for them to act unpredictably or place themselves in danger following a conversation about sex and intimacy (65, +3).

A conversation about sex and intimacy might not be possible if clients have little knowledge about sex and relationships (31, +3), as Participant 26 stated *“A number of clients are unsure about sex”.* When considering whether to initiate conversations about sex and intimacy with clients these participants made informed decisions about any adverse factors that could exacerbate existing difficulties a client might present with. Although the client’s level of social isolation would not necessarily preclude discussions of sex and intimacy, practitioners would be mindful of the impact of a conversation (26, +1), perhaps because of the possible impact of loneliness on the client’s level of distress (53, -1). In terms of clinical work and the progress of therapy, such a discussion may cause otherwise avoidable negative consequences, such as ruptures to the therapeutic relationship (62, +4), as Participant 14 commented: *“If my client misinterpreted my interest this would disrupt the therapeutic alliance considerably and may contribute to complex transference.”*

These participants expressed strong views that the process of engaging in a conversation around sex and intimacy might not be a straightforward process in a clinical setting, and such a conversation might be a challenging experience depending on the specific needs of the client (29, +6). Participant 16 supported this with the statement *‘sex is not something we generally talk about publicly as we might some other things, so we have to recognise that this might be particularly embarrassing, more or less so depending on their own reference points’.* Despite the recognition of important contextual factors that these participants would hold in mind when engaging with clients about sex and intimacy, the potential for distress was not seen as a reason to exclude such conversations (52, +2).

*Summary of Factor B*Participants providing Q-sorts in Factor B focused on the clinical and risk management issues in discussing sexuality and intimacy with clients with psychosis, rather than on exploring sexual relationship needs and desires. Conversations about intimate relationships were not encouraged, and there was a sense that acceptable clinical work could be undertaken without such a conversation taking place. Issues relating to the individual profile and need of each client influenced whether participants would initiate conversations about sexuality, such as the level of risk presented by the client, level of social isolation and knowledge about sexual matters. There were concerns about the impact on the therapeutic relationship if the client’s misinterpretation of the conversation led to confused boundaries.

*Factor C: People with psychosis should be able to talk about sex and intimacy, but perhaps not with me*

Factor C has an eigenvalue of 4.59 and explains 17% of the study variance. This account conveyed participants’ mixed views about the prospect of including discussions about sex and intimacy in work with people with psychosis. There were positive views that people with psychosis *should* be able to talk to professionals about intimate topics, but such conversations may be best addressed by other professionals. These participants believed that they should be available to talk about sexual and relationship needs with people with psychosis (15, +6). Participants recognised that the relationship needs of people with psychosis and the rest of the population do not differ (3, +5), and there was a strong belief that a conversation about sex and intimacy would not impact negatively on clients, and may even result in positive outcomes (53, +4). These participants did not hold the view that sexuality and intimacy is a priority topic that therapist and client can comfortably address in clinical psychology sessions (59, -1). They may initiate such conversations, but only as a necessity if the client wished to address it (21, 0), as Participant 13 commented *‘It is generally a topic which seems to be avoided by other disciplines in mental health services and yet it is a significant part of people’s lives. Someone has to be available to talk with clients about these things if they wish to do so’.*

Several statements in this factor indicated that ambivalence about addressing intimate topics was related to participants’ perceived skills in this area. Conversations about sex and intimacy are apparently an area that would cause some concern for participants, as a distinguishing statement indicated that such topics may be too complex for them to appropriately manage in sessions with clients (41, +6). Such fears may be linked to a gap in training at doctoral level to engage with clients about their intimacy needs (40, +6), as Participant 13 commented *‘for such a complex and immense topic, there was very little in the way of training*…’. The absence of appropriate training or adequate experience in clinical issues in sexuality and intimacy causes these participants to doubt their competency in initiating conversations about intimate topics with clients (43, +2).

Reluctance to engage in conversations about sex and intimacy suggested by this factor also highlights occasions where it may be a necessary subject, as there may be specific circumstances under which clinicians do and do not explore such sensitive issues. Referrals may be made to other professionals, or conversations limited in clinical psychology sessions (2, +3), as *‘it is not necessarily part of my role’* (Participant 12). Participants chose to discuss sexuality from the perspective of exploring the client’s relationship needs or desires, but instead focus on management of other issues such as minimising distress for the client (47, -2). Where it is not essential, a risk assessment with a client with psychosis may not even include issues relating to sex and intimacy (5, +2). An example of a situation where a conversation about sexual experiences occurred might be in response to a client’s disclosure that they have been subject to sexual abuse (6, +3), or if the client wishes to discuss their sexual needs and no other professional has engaged in such a conversation with them (19, +3). Even if a client was in a relationship, participants did not open discussions about sex and intimacy (8, -3).

This factor revealed awareness that a conversation about sexuality and intimacy that was not conducted skilfully might result in difficulties when working with clients. One issue at the forefront of these participants’ thinking was that sexual and intimacy issues may be very difficult matters for a client to discuss with a clinical psychologist (29, +5). Participants were mindful that there may be emotional consequences too (30, +2). Although clinical psychologists are skilled in managing emotionally difficult conversations in general, the possible distress of talking about sex and intimacy needs to be considered before a conversation is initiated (28, +5). Conversations may trigger difficulties for the client (18, -1) resulting in ruptures in the therapeutic relationship and the client feeling less able to talk openly about their difficulties, therefore *‘being mindful of this means taking time so they can build a trusting relationship with me*’ (Participant 13).

*Summary of Factor C*Despite agreement that sexuality and intimacy was a topic that people with psychosis should be able to address with clinical psychologists, participants in Factor C did not feel comfortable undertaking such a conversation themselves. There was a sense that a conversation would take place only if necessary, for example in the absence of a more qualified or experienced professional. Participants doubted their competency in talking about intimate topics - the result of a lack of doctoral training around sexuality and intimacy - and were mindful of the potential distress or discomfort that could result from a conversation not conducted sensitively.

***Consensus statements***

Consensus statements are non-distinguishing items ranked similarly by participants that show comparable rankings across all factors (van Exel & de Graaf, 2005). 21 consensus statements represented agreement on 32% of items in the Q-set. They have been grouped into two perspectives.

The first consensus perspective contained 8 statements and reflected agreement on the role of the clinical psychologist to consider complexity and be respectful in clinical work with people with psychosis. Clinical psychologists should consider the emotional challenges that might be associated with talking about sexuality and intimacy (30), and be mindful that personal characteristics of each client might impact on such a conversation, such as previous experience of sexual abuse (6; 7), the amount of sexual knowledge a client has (32) and the level of social isolation a client is experiencing (26). Participants were also mindful that a conversation might be more complex if a client was negatively affected by antipsychotic medication (14) or was older than them (34). There was general agreement that although other professionals may ask questions about intimate matters (60), a thorough risk assessment would most likely cover sexual and intimate matters (5).

A concurrent perspective demonstrated strong views on misconceptions about people with psychosis in terms of sexual and intimate relationship needs and the impact of mental health on behaviour. The highest possible disagreement was in terms of statements that sexuality was not important to people with psychosis (10). Participants widely recognised that sexual and intimate relationships may be part of someone’s recovery journey (24). There was significant disagreement that people with psychosis that would neither be interested in a sexual relationship or would not ever experience an intimate relationship (11; 12; 13). In addition, there was strong disagreement around assumptions of the abilities of people with psychosis, specifically that they would not be able to maintain a relationship because of social or relationship skills (27; 46). Participants did not feel that a conversation about sexuality and intimacy would result in disinhibited behaviour in an inpatient setting (56) or inappropriate behaviour towards others (50; 55), nor that asking about such a topic would influence a person’s psychotic symptoms (64).

**Discussion**

Three accounts emerged showing the different perspectives of clinical psychologists working with people with psychosis about addressing sexuality and intimacy with their clients.

Factor A revealed a person-centred approach to talking about sex and intimacy with people with psychosis, where clinicians felt comfortable addressing the topic with clients. Psychologists agreed that talking about sex and intimacy is a central aspect of humanity, and many commented that they would not avoid addressing it in their clinical work. They recognised the clinical benefits of exploring relationship needs, including social support that can provide a buffer against potential relapse, and were comfortable managing challenges in the clinical setting such as any distress or discomfort the client might experience.

The importance of incorporating psychosocial factors and considering clients’ broader social needs in psychological interventions with people with psychosis are clear (Bertolote & McGorry, 2005). Recovery models encourage clients to take responsibility for aspects of their own lives, including engaging in meaningful activities and seeking positive social opportunities (Davidson et al., 2007). The importance of social networks and meaningful relationships in the recovery process should not be underestimated, as the social support, sense of belonging and personal meaning may prevent relapse and buffer against future challenges (Soundy et al., 2015).

Clinical psychologists assess and formulate the complex needs of clients (Morberg Pain, Chadwick, & Abba, 2008), and interventions often include integration of numerous psychological approaches, including cognitive-behavioural therapy (e.g. Fowler, Garety, & Kuipers, 1995; Nelson, 2005), family interventions (Bird et al., 2010) and recovery-focused approaches (May, 2004). The ability to appropriately manage complex information is a core clinical skill and is in part what differentiates the profession from others (Division of Clinical Psychology, 2010). Qualified clinical psychologists should be competent in assessing sensitive topics that other healthcare professionals may feel less confident in addressing (British Psychological Society, 2014a).

Factor B highlighted a view amongst some clinical psychologists that conversations with people with psychosis about sexuality and intimacy might be biased towards risk management and considering appropriateness rather than towards exploring intimate relationship needs. The nature of these risks was not explicit from the data. This view indicated that psychological assessment and therapeutic intervention could proceed appropriately without the need to address sex and intimacy. Psychologists were mindful about whether clients would be comfortable with a clinical psychologist initiating a conversation that touched on intimate content. There appeared to be consideration of client-specific contextual factors, such as the level of social isolation a client experienced or their knowledge and understanding of sexual matters.

A focus on management of risk and contextual issues rather than individual relationship needs and desires was evident. Concerns that a client could pose a risk to themselves or others are the primary management issues for clinical psychologists in some clinical settings (Division of Clinical Psychology, 2006b), particularly where client needs are complex and dependent on historical factors e.g. in psychiatric intensive care units and forensic wards (Division of Clinical Psychology, 2007; National Institute for Health and Care Excellence [NAPICU], 2014).

Clinical psychologists working in forensic settings may be less able to undertake recovery-focused therapeutic work than those in other mental health settings, as much of the clinical work undertaken by psychologists in these settings is more likely to focus on targeting offending behaviour, psychological distress or co-morbid substance misuse issues (Barker & Moore, 2006). In addition, conversations about sexuality and intimacy may not be possible or appropriate because clinical psychologists’ work with clients may be provided indirectly, in the form of psychological formulation, consultation and multidisciplinary team meetings (Gudjonsson & Young, 2007).

Factor C indicated that some clinical psychologists may be willing to discuss sexuality but feel limited by their skills. Whilst some clinicians recognise the importance of conversations about sexuality and intimacy, concerns about the outcome from an insensitively approached discussion and limited competency affected willingness to open conversations.

A possible explanation for this lack of confidence in addressing sexuality and intimacy may be the lower level of experience participants had as qualified clinical psychologists. Participants had five years less experience in practice than those in Factor A, and this perspective was supported by qualitative comments about the perceived complexity and lack of training in relation to sexuality.

Findings reflect widespread perceptions that many healthcare professionals are reluctant to talk about sexuality in clinical practice. Studies have identified that avoidance of discussing sexuality with clients is linked to feared consequences, lack of organisational support and lack of training and resources (Dyer & das Nair, 2013). Clinical psychology trainees have previously highlighted a paucity of sexuality and sexual health teaching, resulting in lower confidence and experience in dealing with sexual health matters (Shaw, Butler, & Marriott, 2008). Some clinical psychology training courses do not provide training in sexual therapy or around sexual dysfunction issues (Wiederman & Sansone, 1999). Where training does exist, it tends to focus on sexual violence or specific sexual disorders than on promoting sexual health (Miller & Byers, 2010).

A shared perspective across participants demonstrated that clinical psychologists disagree that sexuality is unimportant for people with psychosis and that they do not have the skills to maintain relationships. Public knowledge about severe and enduring mental health tends to vary depending on how it is examined (Pescosolido et al., 2010; Schomerus et al., 2012) which can result in discrimination and social exclusion for individuals with mental health needs (Rose et al., 2011). A further shared perspective reflected participants’ agreement that it is the role of clinical psychologists to adapt to the nuances of their clinical work and consider personal characteristics and needs when engaging in discussions around sensitive topics. Clinical psychologists are well-placed to challenge misconceptions about psychosis and support their clients in dealing with the psychosocial consequences (British Psychological Society, 2014b).

Whilst a number of psychologists reflected their concerns about the potential risks about opening conversations about sexuality and intimacy, the dominant perspective indicated that there are many who recognise the importance of discussing sexual and relationship issues and currently assess this need as part of their work. These findings appear to be at odds with existing research that has demonstrated reluctance amongst practitioners to explore sexuality (e.g. Dyer & das Nair, 2013). One possible explanation for this is that some psychologists have engaged with the Q-sort in a socially desirable fashion, thus providing responses that make them appear more positive in their roles, which is common in self-report research (van de Mortel, 2008). A further possible explanation is that existing research in this area has focused more on medical and healthcare staff (e.g. Haboubi & Lincoln, 2005).

A need for improved provision of training around sexual health assessment in clinical psychology doctoral programmes is clear. Frameworks exist to support training in sexual health for clinical psychology trainees (Division of Clinical Psychology, 2006a; Shaw, 2006), and many existing tools suggest appropriate questions and language to support practitioners to systematically assess clients’ sexuality and intimacy needs (Butler, O’Donovan, & Shaw, 2010; Mick, Hughes, & Cohen, 2004).

The current NHS climate is one of transformation (Matthews-King, 2018; Mental Health Taskforce, 2016), with increased pressure on psychologists to maintain services in the face of significant pressure (Colley, Eccles, & Hutton, 2015). Guidance laid out by the British Psychological Society suggests that the role of clinical psychology in teams has moved closer to one of leadership, consultation and teaching (Onyett, 2007). This can mean 1:1 clinical time is likely to focus on working with those with severe mental health and complex needs (MIND, 2010; 2013; NICE, 2019). Assessment and intervention around wellbeing issues such as sexuality and intimacy may therefore be carried out by other health professionals supported by training and consultation from a clinical psychologist (Division of Clinical Psychology, 2012).

Future research should explore how clinical psychologists can adjust their practice to incorporate sexual and relationship assessment and intervention into their work within the current NHS structure. This could involve opportunities for working in partnership with existing sexual health services in the UK to offer co-facilitated assessment and guidance (Department of Health & Social Care, 2018).

In addition, Recovery College groups offered in the community and led in partnership between mental health professionals and service-users have shown significant benefits to service-users in terms of satisfaction, learning and positive experience (Meddings, Campbell, Guglietti, Lambe, Locks, Byrne, & Whittington, 2015). Recovery College courses aimed at learning relationship and dating skills may also be of benefit (Harper, 2011).

In terms of study limitations, most of the Q-sort data were collected using an online sorting tool to enable data collection from participants across the UK. Self-report measures are vulnerable to socially desirable responding (Joinson, 1999; van de Mortel, 2008); although participants were encouraged to express their personal views honestly it was not possible to control for such bias. In addition, the level of engagement with the materials can be diminished, and therefore some of the subtlety of sorting is affected because participants are not as able to physically interact with the full range of statements throughout the process (Watts & Stenner, 2012; Brown, personal communication, January 6, 2017).   
  
It may not be possible to apply the findings broadly to clinical psychologists practicing in all domains, as the participant group was limited in representation, comprising a majority of female respondents early in their careers. Respondents worked largely in geographic areas in the West Midlands, which may differ in terms of doctoral course access to training in sexual and relationship topics or to NHS trust or service-level approaches to working with sexual issues relative to other areas of the UK. In addition, because the study failed to explore whether views and attitudes were affected by the clinical setting where participants worked, it is not possible to generalise the findings to different mental health settings, such as forensic settings. Further research would benefit from a demographically diverse sample comprising psychologists from various career points and with a closer examination of how attitudes vary across inpatient and community settings and across services and specialities.

**Conclusion**

This is the first empirical study to explore clinical psychologist’s attitudes around talking about sexual and intimate relationships with people with a severe mental health difficulty. Three distinct viewpoints were identified, broadly demonstrating that whilst many psychologists are comfortable discussing sexuality and intimacy with clients, others focus on the therapeutic appropriateness and potential risks that could be raised by addressing such topics. A further perspective highlighted the lack of confidence and training in this area. Whilst all accounts recognised the importance of sexuality to people with psychosis, perspectives differed in terms of level of comfort with and perceived appropriateness of having conversations with clients in clinical settings.

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**Figure 1. Q-distribution.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Most disagree** | | | | | | |  | | **Most agree** | | | | | | |
| **-6** | **-5** | **-4** | **-3** | **-2** | **-1** | **0** | | **+1** | | **+2** | **+3** | **+4** | **+5** | **+6** |
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**Table 1: Q-set**

|  |  |
| --- | --- |
| **No.** | **Statement** |
| 1 | I would talk about it sex and intimacy if I felt it were relevant and clinically appropriate |
| 2 | I would prioritise other issues in therapy that might not include sex and intimacy |
| 3 | I would consider discussing issues of sex and intimacy just as appropriate with clients with psychosis as I would with clients with any presentation |
| 4 | Any thorough assessment should cover intimate relationships |
| 5 | Asking about sex and intimacy may be necessary as part of a risk assessment |
| 6 | I would ask questions about sex and intimacy if I suspected a person was vulnerable to abuse |
| 7 | I would ask questions about sex and intimacy if I was aware that someone had experienced previous abuse or sexual trauma |
| 8 | I would talk about sex and intimacy if someone was already in an intimate relationship |
| 9 | I would not talk to people experiencing psychosis about sex and intimate relationships as they don’t have any experiences of these things |
| 10 | It is not important for people with psychosis to have sexual relationships |
| 11 | People with psychosis will never have sex |
| 12 | It would be unkind to talk to people about things that are never going to happen for them |
| 13 | People with psychosis are not interested in developing intimate or sexual relationships |
| 14 | Sexual difficulties caused by anti-psychotic medication might affect the ability to have sexual relationships |
| 15 | People should be able to talk to professionals about sex and intimacy |
| 16 | It is important to respect that some people do not want to talk about sex and intimacy |
| 17 | It is important not to make assumptions about a person’s experiences and attitudes towards sex |
| 18 | Asking about sex and intimacy can help some people feel more open to talking about their difficulties |
| 19 | I would talk about sex and intimacy because there may be no-one else who will |
| 20 | I would talk to about sex and intimacy as part of developing a trusting therapeutic relationship |
| 21 | Talking about sex and intimacy is important as it is a major factor in many people's lives |
| 22 | Talking about sex and intimacy is important because it may help someone access much-needed social support |
| 23 | Talking about sex and intimacy is important because the social support people can access may help them prevent relapse |
| 24 | A discussion about sex and intimacy might be an important part of someone’s recovery process |
| 25 | Cognitive impairment might negatively affect the ability to engage in a discussion about sex and intimacy |
| 26 | I would be mindful that a person might be too socially isolated to have intimate relationships |
| 27 | I would not talk about sex and intimacy because I would assume that people do not have the social skills to maintain a relationship |
| 28 | I would be mindful of how uncomfortable and awkward it might be for someone to talk about sex and intimacy |
| 29 | I would be mindful that people might feel too ashamed or embarrassed to talk about sex and intimacy |
| 30 | I would be mindful of the emotional pain of talking about sex and intimacy |
| 31 | I would be mindful that people might struggle to be honest about how much they know about sex and intimate relationships |
| 32 | I like to let people know that it is OK for them to have gaps in their knowledge about sex and intimacy |
| 33 | I would be cautious about talking with someone of the opposite gender about sex and intimacy |
| 34 | I would be cautious about talking with someone who was older than me about sex and intimacy |
| 35 | I like to let people know it is ok to talk about sex and intimacy |
| 36 | I would have to talk about sex and intimacy in order to have a robust and holistic understanding of someone |
| 37 | I would find it hard not to talk about sex and intimacy, as it is often integral to the development of someone’s difficulties |
| 38 | It is important to talk about sex and intimacy as it can be a normalising experience |
| 39 | Talking to people about sex and intimate relationships can provide them with the opportunity to talk about other sensitive areas of their lives that impact on their difficulties |
| 40 | I do not have training to talk to people about sex |
| 41 | I would worry that someone’s sexual issues would be too complex for me to talk about with them |
| 42 | I would not feel comfortable talking about sex and intimacy |
| 43 | I would not feel competent to talk about sex and intimacy |
| 44 | Raising issues of sex and intimacy would be embarrassing for me |
| 45 | I would worry that I would offend someone if I raised sex and intimacy with them in a session |
| 46 | I would not talk to people with psychosis about sex and intimacy because I would not expect them to be a good partner |
| 47 | I would talk about sex and intimacy because I would feel that it is perfectly normal to speak about it in therapy |
| 48 | I would feel disappointed if someone did not raise issues of sex and intimacy with me if it was important to them |
| 49 | Talking about sex and intimacy may not be appropriate if someone is currently unstable |
| 50 | I would not talk about sex and intimacy as someone may become disinhibited |
| 51 | I would not talk to people about sex and intimacy as they may become confused about boundaries |
| 52 | I would not talk about sex and intimacy if I felt it may increase someone’s distress |
| 53 | I don’t think raising issues of sex and intimacy would negatively affect a person’s mental health |
| 54 | I would not talk about sex and intimacy as someone may become aroused by it |
| 55 | I would not talk about sex and intimacy as people can be unpredictable and scary and they may act on our conversations with non-consenting others |
| 56 | I would not talk about sex and intimacy because it might affect someone’s behaviour in a ward environment |
| 57 | I would worry that talking about sex and intimacy might encourage someone to engage in unsafe sex |
| 58 | I would worry that talking about sex and intimacy might result in an unwanted pregnancy occurring |
| 59 | I would feel comfortable discussing sex and intimacy because these topics are part of what it means to be human |
| 60 | I would feel comfortable talking about sex and intimacy because peoples’ needs in these areas are often overlooked or ignored by clinicians and helpers |
| 61 | I would feel comfortable talking about sex and intimacy, as this might be a sign of growing trust and good progress in psychological therapy |
| 62 | I would feel uncomfortable talking about sex and intimacy if I had reason to believe that someone might misinterpret such a discussion as a sign of my own sexual interest in them |
| 63 | I would feel uncomfortable talking about sex and intimacy if the acts of thinking and talking about these subjects might be too distressing for someone to manage |
| 64 | I would feel uncomfortable talking about sex and intimacy because it may add to a person’s persecutory beliefs |
| 65 | I would feel uncomfortable talking about sex and intimacy if it significantly increased the risk of someone subsequently placing themselves in a vulnerable situation |
| 66 | I would feel uncomfortable talking about sex and intimacy if it significantly increased the risk of someone subsequently harming themselves or someone else |

**Table 2: Participant demographics**

|  |  |
| --- | --- |
|  |  |
| Gender | Number of participants |
| Female | 21 |
| Male | 6 |
|  |  |
| Age group |  |
| 30 – 34 | 8 |
| 35 – 39 | 5 |
| 40 – 44 | 8 |
| 45 – 49 | 3 |
| 50 – 54 | 2 |
| 55 – 59 | 1 |
|  |  |
| Location |  |
| East Midlands | 1 |
| West Midlands | 22 |
| South East | 1 |
| East of England | 1 |
| North East | 1 |
| North West | 1 |
|  |  |
| Years since qualification |  |
| 1 – 4 | 12 |
| 5 – 9 | 6 |
| 10 – 14 | 4 |
| 15 – 19 | 3 |
| 20 – 25 | 1 |
| 25 + | 1 |
|  |  |
| Years in current post |  |
| Less than 6 months | 2 |
| 6 months – 1 year | 4 |
| Over a year | 5 |
| 2 – 4 years | 7 |
| 5 – 9 years | 5 |
| 10 – 14 years | 3 |
| 15 + years | 1 |
|  |  |
| Current professional role |  |
| Clinical psychologist | 9 |
| Senior clinical psychologist | 7 |
| Consultant/Principal clinical psychologist | 10 |
| Did not state | 1 |
|  |  |
| Service setting |  |
| Inpatient | 6 |
| Community | 16 |
| A combination of both | 5 |

**Table 3: Rotated factor matrix showing factor loadings.**

|  |  |  |  |
| --- | --- | --- | --- |
| Participant | Factor 1 | Factor 2 | Factor 3 |
| 1 | 0.5967X | 0.3617 | 0.4726 |
| 2 | 0.6362X | 0.586 | 0.1164 |
| 3 | 0.8000X | 0.2051 | 0.2252 |
| 4 | 0.3861 | 0.6071X | 0.2709 |
| 5 | 0.5558 | 0.6185 | 0.3527 |
| 6 | 0.5217 | 0.5872 | 0.3386 |
| 7 | 0.7715X | 0.2916 | 0.2881 |
| 8 | 0.5809 | 0.6071 | 0.3036 |
| 9 | 0.2337 | 0.5682X | 0.5095 |
| 10 | 0.8219X | 0.4041 | 0.0908 |
| 11 | 0.8882X | 0.2024 | 0.021 |
| 12 | 0.2018 | 0.4172 | 0.7410X |
| 13 | 0.1686 | 0.3167 | 0.8126X |
| 14 | 0.0258 | 0.7762X | 0.3814 |
| 15 | 0.7759X | 0.296 | 0.2476 |
| 16 | 0.3877 | 0.7629X | 0.3375 |
| 17 | 0.6764X | 0.5783 | 0.1733 |
| 18 | 0.8062X | 0.3317 | 0.1874 |
| 19 | 0.264 | 0.3617 | 0.7500X |
| 20 | 0.4688 | 0.4127 | 0.5178 |
| 21 | 0.6376X | 0.4414 | 0.2181 |
| 22 | 0.7560X | 0.2755 | 0.379 |
| 23 | 0.4508 | 0.7230X | 0.3063 |
| 24 | 0.6297X | 0.5111 | 0.3444 |
| 25 | 0.7604X | 0.0547 | 0.4835 |
| 26 | 0.3079 | 0.6979X | 0.312 |
| 27 | 0.6853X | 0.2186 | 0.5208 |

|  |  |  |  |
| --- | --- | --- | --- |
| **Table 4. Participant demographics for each factor.** |  |  |  |
|  | Factor A (*n* = 14) | Factor B (*n = 6)* | Factor C (*n* = 3) |
| Gender |  |  |  |
| Female | 11 | 4 | 2 |
| Male | 3 | 2 | 1 |
|  |  |  |  |
| Age group |  |  |  |
| 30 - 34 | 5 | 1 | 1 |
| 35 - 39 | 3 | 1 | 1 |
| 40 - 44 | 4 | 1 | 1 |
| 45 - 49 | 1 | 2 | - |
| 50 - 54 | - | 1 | - |
| 55 - 59 | 1 | - | - |
|  |  |  |  |
| Years since qualification |  |  |  |
| 1 - 4 | 6 | 2 | 3 |
| 5 - 9 | 3 | 3 | - |
| 10 - 14 | 2 | - | - |
| 15 - 19 | 3 | - | - |
| 20 - 25 | - | 1 | - |
| 25 + | - | - | - |
|  |  |  |  |
| Years in current post |  |  |  |
| Less than 6 months | 1 | - | 1 |
| 6 months - 1 year | 1 | 2 | - |
| Over a year | 2 | 1 | 2 |
| 2 - 4 years | 4 | 1 | - |
| 5 - 9 years | 2 | 2 | - |
| 10 - 14 years | 2 | - | - |
| 15 + years | - | - | - |
|  |  |  |  |
| Current professional role |  |  |  |
| Clinical psychologist | 5 | 2 | 1 |
| Senior clinical psychologist | 1 | 2 | 2 |
| Consultant/Principal clinical psychologist | 7 | 2 | - |
| Did not state | 1 | - | - |
|  |  |  |  |
| Proportion of time working with psychosis (%) |  |  |  |
| 0 - 25 | 5 | 2 | 1 |
| 26-50 | 3 | 2 | 1 |
| 51-75 | - | 1 | - |
| 76-100 | 6 | 1 | - |
| Did not state | - | 0 | 1 |