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Creating the Therapeutic Environment: An Exploration of Art Therapy and Sexuality

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CREATING THE THERAPEUTIC ENVIRONMENT: AN EXPLORATION OF ART THERAPY AND SEXUALITY

by

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Disclaimer

This paper does not reflect the views of Loyola Marymount University nor the Department of Marital and Family Therapy. Prior to data collection, an Institutional Review Board (IRB) approval for the research was obtained. Appendices contains IRB letter of approval.

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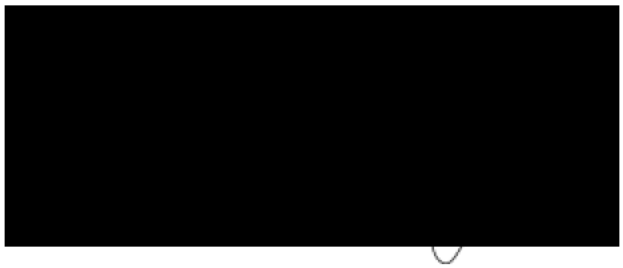

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Abstract

This research explored how art therapists create a safe and inviting environment for clients to discuss topics related to sex and sexuality in therapy. Our research consisted of three main questions: How do art therapists use art therapy techniques, materials, and directives to create a therapeutic environment in which clients can open up about their sexuality? How comfortable and/or experienced are therapists regarding discussion of topics related to sex and sexuality with clients in therapy sessions? What barriers are there to discussing sexuality in therapy, and how does art help overcome those barriers? Our research subjects were practicing art therapists who are alumni of the Marital and Family Therapy program at Loyola Marymount University. We utilized a mixed methods approach through a Qualtrics survey consisting of quantitative, likert-scale questions, as well as qualitative open-ended questions and an optional art making response, and qualitative data gathering through a singular interview including an art response. Through analysis and discussion of the data collected, we identified ways in which art therapy facilitates conversations about sex and sexuality, and ways in which barriers to these conversations and the utilization of art-making to explore them still exist. The data also revealed the importance of therapists' own comfort level and education regarding these topics, as well as how therapists' cultural backgrounds contribute to their comfort and motivation to invite these discussions and to seek out continuing education to increase their clinical competence exploring sex and sexuality in sessions with clients.

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Finally, we would also like to acknowledge the friends and loved ones who have supported us emotionally throughout this project and the rest of graduate school. In particular, our respective cats, Gus and Lynx, who we must thank for the endless cuddles and comfort, and for occasionally staging a sit-in on our keyboards to remind us to take breaks. We would also like to thank each other - for being communicative, prompt, flexible, and encouraging partners throughout this process, as there were times where it seemed endless, but would have felt much longer if it had been done alone.

Dedication

This project is dedicated to anyone who has ever felt curious, confused, eager, conflicted, anxious, excited, judged, or elated about sex, sexuality, or their sexual identity. The nuances of being human can be complex, and often hidden. We see and appreciate your journey--we hope to provide steps for the world with accessible support, resources, and knowledge to make this journey easier and more full of joy and freedom. Thank you for being you.

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Introduction

The Study Topic

Our research explored how art therapists create a safe space for clients to discuss topics related to sex and sexuality in the therapeutic space. We sought to understand what barriers and challenges there are to conversations around these topics in therapy, and if, and how, art therapists use art therapy techniques, directives, and materials to overcome these barriers and facilitate clients' disclosure and exploration of sex and sexuality. Specifically, our research looked at art therapists working with adult clients discussing these topics in therapy. The focus of the research was to attempt to understand art therapists' experiences discussing sex and sexuality with clients, and if, and how, they perceive that art therapy has aided that conversation. We used a mixed methods approach, utilizing quantitative data gathering through a Qualtrics survey which included an optional art response, and qualitative data gathered from a semi-structured interview which included art-making.

Significance of the Study

This topic of study is important to the field of art therapy because the potential for art therapy to help encourage the client's sense of safety and willingness to discuss the very personal topics of sex and sexuality has not often been explored in these parameters before. Through our research, we collected data with the goal of identifying how art therapy helps to facilitate discussions of sex and sexuality in therapy, and how it may aid in overcoming barriers and challenges to such discussion that talk therapy alone may not be enough to overcome. We hope our findings will add to the limited amount of research on this topic within the art therapy field, and encourage further research on this topic.

This topic is very important to us, as we are currently seeing clients in our practicum placements, and we will be graduating and becoming practicing clinicians and art therapists in the near future. Because of this, we highly value creating the most optimal feeling of safety and security in the therapeutic space for our clients, especially concerning topics such as sex and sexuality which are often considered shameful or "taboo." According to Goettsch (1989), the language and scope of sexuality have changed in society drastically through time, and the definition of sexuality is person-dependent. The researchers find Goettsch's (1989) literature to be significant in regards to this topic, as it demonstrates that these conversations, the scope of sexuality, and changes to terms and language used to discuss it, have been ongoing. Thus, as therapists, we consider it essential to be an ally to the communities and populations we serve, by both understanding current terminology and providing a safe and inviting space for clients to be open about their sexual identities and experiences of sexuality.

Background of the Study Topic

Sex is a natural, human act that is still considered taboo in our society, at times causing individuals to feel shame and guilt when thinking or talking about it (Foucault, 1978). Considerable research in the field of psychology has found that sex is one of the most difficult topics for clients to talk about in therapy (Bauman & Hill, 2016; Love & Farber, 2017). Research in the fields of marital therapy and couples therapy has found that even in these forms of therapy which focus on relationships, sex is often not discussed openly in sessions (Johnson & Zuccarini, 2009; Timm, 2009). Similarly, Metzl (2017) noted that even clients who specifically seek out sex therapy when they are dealing with sexual issues often struggle to overcome feelings of shame or

guilt before they can talk about these topics, due to stigma from dominant cultural norms about sex and sexuality.

Additionally, clients identifying as sexual minorities may face extra barriers to disclosure and discussion of sexuality in therapy. Due to cultural biases and beliefs, and the potential for heteronormative assumptions and microaggressions, it is often more challenging for clients who identify as LGBTQIA, non-monogamous, polyamorous, or kinky to discuss sex and sexuality in therapy (Hogan, 2012; McGeorge & Carlson, 2009; Shelton & Delgado-Romero, 2011). Studies that have been done in the field of talk therapy examining therapists' comfort levels discussing sexuality in sessions with clients have identified that factors such as personal biases and beliefs, as well as limited education on topics of sexuality, can contribute to therapist discomfort and avoidance of these topics (Gochros, 1986; Love & Farber, 2017). Similarly, researchers have noted that clients themselves are often reluctant to bring up these topics due to feelings of shame, embarrassment, or fear of judgment (Bauman & Hill, 2016).

Art Therapy is a modality that helps clients express thoughts and feelings that are difficult to talk about, or that they might struggle to put into words (Betensky, 1977; Wadeson 2010). Art therapists also observed that the act of making art can reveal unconscious thoughts, feelings, and desires (Junge, 2010). There is some limited research on the use of art therapy to help clients discuss sexuality (Metzl, 2017; Pelton-Sweet & Sherry, 2008), but the majority of the research in this field focuses on art therapy as a treatment for sexual trauma (Brooke, 1995). There has been less research done on how art therapy can help clients explore sexual identity, sexual pleasure, and sexual issues in relationships.

Of the existing research, many art therapy studies have focused on sexual minorities such as LGBTQIA clients (Addison, 1996; Brody, 1996; Ellis, 2007; Pelton-Sweet & Sherry, 2008) and the transgender community in particular (Barbee, 2002; Beaumont, 2012; Piccirillo, 1996; Zappa, 2017), while others have focused on clients dealing with sexual problems such as sex addiction (Fischer & Wilson, 2018; Wilson, 1999). There is also a small but growing amount of research on the use of art therapy in combination with sex therapy (Barth and Kinder, 1985; Kahn, 2013; Metzl, 2017). Many of these studies have found that specific directives and materials have been helpful in facilitating clients' explorations of sex and sexuality through art-making (Brody 1996; Pelton-Sweet & Sherry, 2008). However, we found that the research on these topics within the art therapy field is still limited, which motivated our research on this subject.

Literature Review

Introduction

Sex and sexuality have always been a natural and important part of human existence, although our society has curated a taboo culture that often inhibits discussion about them. Even in the therapeutic environment, where clients are invited to open up and discuss anything, including sexuality, many clients feel insecure or ashamed to talk about this subject. Clients may fear that such discussion could evoke judgment or discomfort on the part of the therapist, as the dominant culture exerts its influence even on this space. Yet throughout history, art-making has given individuals a way to voice their thoughts and feelings about sex and sexuality, as they have used visual imagery to explore these confusing and taboo subjects. As researchers, we wanted to find out how art therapists use art therapy techniques, materials, and directives to create a therapeutic environment in which clients can open up about their sexuality and explore it further. Our review of the existing art therapy literature revealed research exploring how art can be a tool to facilitate therapeutic conversations - allowing the client to express ideas that may be embedded in shame or guilt, or concepts that may be difficult to verbalize. However, we found that the research within this field is limited, and often focuses solely on select populations while neglecting others. So we broadened our search to gain a fuller understanding of how art can help clients talk about sex and sexuality.

The literature we examined within this review spanned both research from the art therapy field as well as research from other disciplines within therapy, psychology, and art history. In order to provide consistency and clarity for our readers, we began our literature review by identifying and defining important key terms and identities that we used throughout this review.

After grounding the reader in key terminology, we examined literature exploring why the topics of sex and sexuality are often difficult, considered taboo, or associated with shame, and how this makes them challenging for people to talk about both in and outside of therapy. Next, we explored research on how these topics are addressed in talk therapy, paying special attention to research on therapy with marginalized groups and sexual minorities, including clients identifying as LGBTQIA, non-monogamous, or kinky. We reviewed studies that have investigated client disclosure about sexuality and sexual issues in therapy, as well as research examining therapists' own comfort levels when it comes to discussing these topics in treatment. Additionally, we looked at literature which has identified ways in which therapists can work to make their practice culturally humble and affirming of marginalized sexual identities.

We connected this research to art therapy by delving into the limited art therapy literature addressing sexuality and the use of art-making as means to facilitate discussions of sexuality within therapy. In this section, we reviewed research that analyzed how art therapy can be especially helpful for clients discussing difficult topics, or thoughts and feelings they might struggle to put into words. We covered the existing research concerning the use of art therapy with LGBTQIA clients; with clients exploring issues of gender, sexual problems, and sexual assault; and the use of art therapy in marital therapy and sex therapy. We concluded our exploration of this literature on both talk therapy and art therapy with a discussion of how the connections between research from these different areas within psychology support the use of art therapy to explore sexuality. Lastly, we identified the limitations of current research and the potential for future investigation on this topic.

Key Terms and Identities

Since the literature we are reviewing covers many different sexual identities and practices, we chose to provide definitions of key terms that are often misunderstood, or that readers may not be familiar with. Some of the older literature we examined also used terminology that was accepted at the time but would be considered offensive or outdated today, so in our review we have attempted to consistently use accurate contemporary terminology. Additionally, because identity is so personal and important, particularly to sexually marginalized individuals, we have chosen our wording with care to be considerate and sensitive to the populations we are writing about.

Asexual: Having little sexual desire or no sexual desire at all. (Steelman & Hertlein, 2016).

BDSM: Bondage and discipline (B/D), dominant and submissive (D/s), and sadism and masochism (S/M) (Pillai-Friedman, Pollitt, & Castaldo, 2015).

Bisexual: Being sexually attracted to both sexes (men and women) (Hogan, 2012, p. 57).

Cisgender: The sense that one's "personal identity and gender correspond to biological sex" (Zappa, 2017, p. 129).

Coming out: Disclosing one's sexual orientation, or, in the case of transgender individuals, disclosing one's gender identity (Pelton-Sweet & Sherry, 2008, p. 170). Pelto-Sweet & Sherry note that "many people experience coming out as a continuous and lifelong process. This is especially true, for example, for bisexuals who are married to differently-gendered partners, because they face the additional challenge of countering assumptions of heterosexuality" (p. 171)

Gay: A man who is sexually attracted to other men (Hogan, 2012, p. 57).

Gender: Sing, Boyd, & Whitman (2010) report that "*gender* is defined by society and reflects the social norms of what is considered to be feminine and masculine" (p. 416).

Gender-independent: Not identifying as either male or female. Zappa (2017) suggests the use of this term "to avoid suggesting that there is a standard gender to which people need to conform. . . . to include people who are gender nonconforming, as well as people with other nonbinary gender identities and expressions" (p. 129).

Heterosexism: "this term was created as an alternative to the more common term 'homophobia,' in order to highlight the similarities between the oppression between lesbian, gay, and bisexual persons, and the oppression of women and people of color...it refers to a systematic process that simultaneously grants privileges to heterosexuals and oppress LGB persons" (McGeorge, C. & Carlson T.S., 2011).

Intersex: Individuals whose biology is such that they "cannot easily be categorized as male or female" (Singh, Boyd, & Whitman, 2010, p. 417) due to anatomical or chromosomal variations.

Kink: Pillai-Friedman, Pollitt, & Castaldo (2015) stated that "the terms kink and kinky sex are often used to describe a variety of BDSM practices" as well as the culture around these practices (p. 197-198).

Lesbian: A woman who is sexually attracted to other women (Hogan, 2012, p. 57).

LGBTQIA: Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual

Monogamy: According to Merriam-Webster, monogamy is defined as the state or custom of being married to only one person at a time.

Mononormativity: the widely held assumptions of the normalcy and naturalness of monogamy. (Monogamy, n.d.)

Non-monogamy: According to Merriam-Webster, non-monogamy is defined as not of, relating to, or practicing monogamy. (Nonmonogamous, n.d.)

Polyamory: a term used to describe relationship models wherein individuals pursue multiple concurrent romantic relationships with the permission of their partners (McCoy, Stinson, Ross, & Hjelmstad, 2015).

Queer: According to Vanderbilt University ("Definitions," n.d.), queer is defined as a sexual orientation which advocates breaking binary thinking and seeing both sexual orientation and gender identity as potentially fluid. The term is a simple label to explain a complex set of sexual behaviors and desires. For example, a person who is attracted to multiple genders may identify as queer. Many older LGBT people feel the word has been hatefully used against them for too long and are reluctant to embrace it. "Queer" can be used as an umbrella term to refer to all LGBTQIA individuals.

Sex: "The physiological determinants of 'male' and 'female'," (Singh, Boyd, & Whitman, 2010).

Sex Addiction: The term "sex addiction" is not considered a disorder in the DSM-V, but Metzl (2017) notes that "the conceptualization and terminology of 'sex addiction' seem to have found a solid presence in both popular media and expert niches of the clinical community over the last decade and a half" (p. 168).

Sexual Orientation: One's "emotional, romantic, or sexual attraction to persons of a particular sex" (Hogan, 2012, p. 57). Hogan (2012) notes that sexual orientation is not something that one chooses, and it can be harmful to attempt to "change" a person's sexual

orientation (p. 57).

Transgender: Singh, Boyd, & Whitman define *transgender* as "an umbrella term that refers to individuals whose gender identity transgresses traditional definitions of 'male' and female'. Many of these individuals experience themselves as a gender other than the one to which they have been assigned" (p. 417).

Sex and Sexuality

A broad review of the literature on sex and sexuality in our society inevitably focuses on how this natural, human act came to be considered taboo. Foucault (1978) described how sexuality, once openly spoken of, came to be associated with shame and guilt in western cultures in the seventeenth century (p. 3). That sense of shame and guilt persists in our society today, as Pukall (2009) observed that "North American society is uncomfortable (to put it mildly) with anything sex-related" (p. 1039). Metzl (2017) noted that even discussing the positive, pleasurable aspects of sexuality is "complicated by our morals and social norms" (p. 15), and talking about problems and insecurities is thus even more challenging. Additionally, O'Donovan & Butler (2010) noted that homosexuality was once pathologized by the field of psychiatry, and society and many religions have only deemed heterosexual sex permissible within the context of marriage, emphasizing the purpose of procreation, rather than pleasure. O'Donovan and Butler (2010) also pointed out that masturbation is disapproved of in many cultures, and is taboo to talk about in western culture, along with other sexual behaviors such as oral sex and anal sex. In contrast with the message that sex is a taboo subject, much of western media and pop culture is filled with information, ideas, and images regarding sex (Gochros, 1986). Our research indicated

that the complicated relationships between sexuality as a basic human need, social and cultural norms, and media representations of sexuality contribute to both the importance and the challenges of discussing this topic in therapy.

Talk Therapy and Sexuality

Although therapy is meant to be a place where clients can openly talk about anything, social norms and shame from the dominant culture often extend into the therapeutic space, making sex and sexuality difficult topics for clients to bring up or discuss. Analyzing why these topics are so particularly challenging for both clients and therapists, Gochros (1986) observed that "there is no area of human life more cloaked in secrecy, hypocrisy, inconsistency, ambiguous legality, ignorance and emotionalism than sexuality" (p. 9). Gochros went on to note that although there are explicit depictions and discussions of sex in the media and popular culture, individuals often still feel that their own sexuality is too private to discuss with anyone else. And depending on how an individual was raised, they may have received messages from their family or culture teaching them that sex is shameful, dirty, or wrong (p. 11).

Over thirty years after the publication of Gochros's (1986) article, Love & Farber (2017) found that these barriers to open discussion of sexuality still exist in our society and in therapy sessions. But the researchers noted that despite the challenges, talking about sex and sexuality can be very important to the client's process, and "can provide critical insight into their relationships, their emotional well-being, and their physical health" (Love & Faber, 2017, p. 1489). Walters & Spengler (2016) also identified that "more widespread viewing of pornography, and client concerns related to pornography, have lead to a growing need for therapists to be trained to address this topic, as it is yet another aspect of sexuality in which

stigma and shame can inhibit honest discussion" (p. 354), suggesting that as time goes on the need for conversations about these topics only increases.

Marital Therapy and Couples Therapy.

Even in marital and couples therapy, forms of treatment focused on relationships, the literature we reviewed shows that sex can still be a taboo subject for clients (Johnson & Zuccarini, 2009; Metzl, 2017; Timm, 2009). In an article advocating for greater inclusion of this topic in couples therapy, Timm (2009) noted that "sexuality is an integral part of a couple's relational dynamics, whether the therapist is asking about it or not" (p. 15). Timm provided evidence of this by citing statistics from multiple surveys that revealed a high prevalence of sexual problems reported by individuals and couples, which inevitably impact their relationships (p. 16). Johnson & Zuccarini (2009) similarly pointed to statistics showing that troubles in couples' relationships often include issues related to sex, and noted that while some couples counselors may prioritize treatment for the relational problems and hope that this will lead to improvement of the sexual problems, other counselors take a more proactive approach and invite discussion of the sexual issues in therapy along with the relational issues. Johnson and Zuccarini observed that the result of this is that "the line between sex and couples therapy is becoming finer and finer" as more couples counselors make the effort to address sexuality in treatment (p. 1).

Sex Therapy.

The literature we reviewed on the topic of sex therapy pointed out that even in this form of therapy, which includes the word "sex" in its name, it can still be challenging for clients to open up about this topic. The stigma against talking about one's sexuality is so deeply-rooted for

some clients that overcoming that sense of fear and shame can be a significant challenge (Henderson, 2013; Metzl, 2017; Pukall, 2009; Tabatabaie, 2014). Tabatabaie (2014) defined sex therapy as "a specialised form of talking therapy that uses a range of interventions to effectively treat male and female sexual problems" (p. 269), and noted that sex therapy addresses both problems with sexual dysfunction and emotional problems (p. 270). Henderson (2013) emphasized the ability of sex therapy to go beyond merely helping clients to resolve sexual issues, as it can also aid them in exploring greater pleasure and intimacy in their sex lives (p. 132). By creating a space set aside specifically for discussion of sexuality, Pukall (2009) speculated that sex therapy may have emerged as its own field precisely because sex was so often not discussed in other modalities of therapy (p. 1039).

Although clients come to sex therapists seeking help with sexual problems, Metzl (2017) noted that "often dialogues about sexuality in treatment lead to shame. At best, the shame is not experienced by the client, but still deflected toward him/her through a shaming society or the shameful experiences of important others" (p. 72). Clients questioning their sexual orientation, dealing with sexually transmitted diseases, or struggling with sex addiction face additional stigma from the dominant culture. Furthermore, clients seeking help for anything outside the norms of heterosexuality or monogamy may feel extra layers of shame (Metzl, 2017, p 73). For this reason, we chose to go on to review research specifically examining therapy with these sexually marginalized groups.

Therapy with LGBTQIA Clients.

Even the term "therapy" itself can bring up negative associations for the LGBTQIA community. According to Hogan (2012), "historically, 'conversion therapy' and 'reparative

therapy' techniques were used by therapists who viewed homosexuality as unhealthy and something that could be changed" (p. 55). Ford (2011) stated that the concept of 'conversion therapy' or 'reparative therapy' was originally introduced by the Elizabeth Moberly in the 1980s. Since then, many Christian and other religious fundamentalist psychotherapists have adopted this practice as a "cure" for homosexuality or non-heteronormative sexual preference. Proponents of 'conversion therapy' or 'reparative therapy' argue that homosexuality is pathological, originating from an issue with a child and their same-sex parent. The goal of 'conversion therapy' or 'reparative therapy' is the find the unmet needs of the "wounded" individuals, and their true identity as a heterosexual individual will emerge (Ford, 2011).

'Conversion therapy' or 'reparative therapy' continues to be practiced by some mental health professionals, despite the numerous organizations that have denounced it for being unethical and damaging to clients, since homosexuality is no longer defined by the field of psychology as an illness or an issue that needs correction (Addison, 2003). Most therapy today emphasizes the importance of cultural humility to affirm and welcome all identities, and works toward diminishing and even legislating against the practice of "conversion therapy" for the LGBTQIA community. But even in the realm of affirmative therapy, Singh, Boyd, & Whitman (2010) report that transgender clients may still feel "insulted" by the fact that they are often required to obtain a letter from a mental health professional prior to seeking gender-confirming surgery, which imposes a power dynamic on the therapeutic alliance that may create a barrier to building rapport (p. 423). And Magee & Spangaro (2017) pointed out that past negative experiences in therapy or other healthcare settings can still contribute to client fear or reluctance to disclose their sexual orientation or gender identity today (p. 358).

Much of the literature we reviewed noted that even therapists who do not support reparative or conversion therapy may be influenced by the heteronormative bias of the dominant culture, which can lead them to make assumptions about a client's sexual orientation (Hogan, 2012; McGeorge & Carlson, 2009; Shelton & Delgado-Romero, 2011). Hogan (2012) noted that since sexual orientation is not something that is necessarily visible, therapists may not know that their clients are members of the LGBTQIA community (p. 54). And McGeorge & Carlson (2009) pointed out that "a common heteronormative assumption that heterosexual therapists may make is that every client who seeks therapy is in a heterosexual relationship or of a heterosexual sexual orientation" (p. 2). Shelton & Delgado-Romero (2011) also found that therapists may hold stereotypical views of LGBTQIA individuals, as evidenced by reports from clients about experiences in therapy where therapists had "warned" them of the "inherent dangers associated with an LGBT identity" (p. 216), further perpetuating the harmful narrative that homosexuality is innately linked to a negative quality of life, and potentially contributing to greater internalized homophobia for these clients (p. 218).

Magee & Spangaro's (2017) study about same-sex attracted female clients observed that while social stigma and discrimination can create barriers to discussions or disclosure of sexual orientation, if therapists advertise themselves as LGBTQIA friendly, clients will feel more inclined to participate in services offered, and to disclose their sexual orientation (p. 351). Magee & Spangaro (2017) also emphasized that it is especially challenging for clients to come out to their therapist if they are not out to others in their lives, and if they are dealing with internalized homophobia or transphobia - making it all the more important for therapists to demonstrate to clients that they are affirming and nonjudgmental (p. 351). Some therapists who are themselves

members of the LGBTQIA community may choose to disclose this to their LGBTQIA clients in order to help build rapport and show that they are affirming. But Magee & Spangaro's (2017) study found that such self-disclosure from the therapist was less helpful to clients than an affirmative, open, nonjudgmental therapeutic relationship (p. 352), and the client's own "readiness" to come out in therapy (p. 356-357).

Magee & Spangaro (2017) reported that some of the ways in which therapists can convey messages of openness to clients include the use of LGBTQIA symbols on brochures and pamphlets, as well as gender neutral language in conversation and on intake forms and other paperwork (p. 355). McGeorge & Carlson (2011), Shelton & Delgado-Romero (2011), and Singh, Boyd, & Whitman (2010) also identified how the use of LGBTQIA language (correct terms for specific identities, as well as language conveying an understanding of gender differences and sex difference) can indicate to clients that a therapist is LGBTQIA-affirming. And Singh, Boyd, & Whitman (2010) emphasized that when working with transgender and intersex clients, "it is respectful and necessary to ask the client which, if any, pronoun and name is appropriate to use in reference to the client" (p. 426).

Many researchers also took care to point out that therapists should also be conscious of the fact that being a member of the LGBTQIA community does not necessarily constitute the main reason that a client comes to therapy (Magee & Spagaro, 2017; McGeorge & Carlson, 2011; Shelton & Delgado-Romero, 2011). Shelton & Delgado-Romero's (2011) research found that many LGBTQIA clients reported frustration with experiences where therapists had assumed that the clients' presenting problems were due to their sexual orientation (p. 214). Assumptions like this contribute to the microaggressions that LGBTQIA clients experience both in society at

large as well as in therapy. Shelton & Delgado-Romero (2011) also pointed out that therapist "over-identification" with LGBTQIA clients, in an exaggerated attempt to convey comfort and an affirming attitude, can end up coming across as non-affirming instead. Their study found that several therapists working with LGBTQIA clients altered their vocal tones, facial expressions, and postures in attempt to demonstrate understanding and acceptance to their clients. But the research showed that this was actually likely to deter clients from feeling a sense of authenticity in the therapeutic alliance (p. 215).

Some of the research we reviewed noted that even though there has been a shift away from conversion therapy towards affirmative therapy, and in many ways our society has become more accepting of LGBTQIA individuals, many therapists still have little training or experience working with this population (McGeorge & Carlson, 2011; Singh, Boyd, & Whitman, 2010). Singh, Boyd, & Whitman (2010) pointed out that there is a particular dearth of such competency when it comes to therapists working with transgender and intersex clients (p. 415), and stated that it is important for therapists to recognize this and seek further education and training so that they can adequately serve the needs of these clients (p. 422). McGeorge & Carlson (2011) also emphasized that in order to be LGBTQIA-affirmative, therapists must acknowledge the higher rates of depression, anxiety, and substance use amongst LGBTQIA clients as a consequence of heterosexism and the heteronormative life stress (p. 3), and therapists must also examine how their own values and biases have been influenced by a heteronormative lens (p. 6). McGeorge & Carlson (2011) concluded their research with a reminder that no therapist will ever be completely free of heteronormative influences, but through awareness of their "heterosexist blind spots" (p. 8) they can continue working towards being affirmative allies to the LGBTQIA community.

Monogamy and Non-monogamy.

For clients of all sexual orientations, discussion of their relationships or desired relationships can be an important part of treatment, whether in individual or couples therapy. Although monogamy is the social expectation for relationships in the U.S. and many other Western countries, therapists are likely to also encounter clients who choose to engage in non-monogamous relationships. The term "non-monogamous" means that a relationship is not sexually exclusive and may include more than two partners (Girard & Brownlee, 2015, p. 463). Different types of non-monogamous relationships might include: open relationships, open marriages, polyamorous relationships, swingers, and other forms of relationships that the participants define for themselves (Finn, Tunariu, & Lee, 2012; Girard & Brownlee, 2015). Additionally, the term "consensual non-monogamy" is often used to clarify that these relationships are based upon mutual agreement of all parties involved, in contrast to relationships where a monogamous agreement is breached by a partner committing infidelity against the other partner's wishes, or without the other partner's knowledge (Finn et al., 2012, p. 205; Girard & Brownlee, 2015, p. 463). Sprott, Randall, Davison, Cannon, & Witherspoon (2017) pointed out that statistics on the number of people who are in or have previously been in non-monogamous relationships suggest that it is likely that therapists will find themselves working with clients in non-monogamous relationships, even if that fact is not something clients disclose (p. 930).

The literature we reviewed on this subject emphasized that social stigma against non-monogamous relationships can pose a challenge to disclosure and discussion of such relationships in therapy (Finn et al., 2012; Girard & Brownlee, 2015; McCoy, Stinson, Ross, & Hjelmstad, 2015). According to Finn et al. (2012), the attitudes of U.S. sex and relationship

therapists towards open or non-monogamous relationships have historically been unfavorable, and therapists have held biased beliefs about the quality of relationships and attachment styles of individuals who practice non-monogamy (p. 206). McCoy et al. (2015) noted that non-monogamous clients who come to therapy for problems not related to their relationships may fear that a biased therapist will pathologize the non-monogamous relationship as the presenting problem (p. 138). The research done by Finn et al. (2012) pointed out that therapists who espouse the values of the dominant, monogamous culture can perpetuate societal stigma and judgment in the therapeutic space (p. 211). Love & Farber (2015) stated that: "Therapists may find it difficult to handle disclosure about sexuality in a culturally sensitive, nuanced way, as much of the clinical and empirical literature on sex and marital therapy has been written from a Western, heterosexual, and dyadic perspective" (p. 1490). Girard & Brownlee (2015) echoed these sentiments, noting that there is a cultural formula that perpetuates a heterosexual, dyadic, monogamous relationship, and deviating outside of that creates a marginalization amongst peers, as well as ostracization and challenges from clinical and scholarly communities (p. 462). The literature we reviewed indicated that the heteronormative lens in which sexuality is discussed and researched may influence therapists' comfort levels and abilities to be affirming when confronted with a non-monogamous relationship (Finn et al., 2012; Girard & Brownlee, 2015; Love & Farber, 2015).

Additionally, Girard & Brownlee (2015) found that many clinicians lack the basic tools and skills to work with clients in sexually open relationships, which puts them at a further disadvantage, having insufficient resources to discuss clinical considerations for these couples. McCoy et al. (2015) echoed these sentiments, noting the lack of research on this subject, and

cited a study which found that most graduate mental health training programs do not mention this type of relationship in their textbooks, curricula, or internships (Weitzman, 2006). Finn et al. (2012) noted that the majority of non-monogamous relationships in the U.S. and UK belong to gay men. Although this statistic should not mislead therapists to assume that non-monogamy is only practiced by gay clients, the researchers identified an "affirmative" style of therapy for non-monogamous clients, similar to the model of LGBTQIA-affirmative therapy, to help therapists work with non-monogamous clients in a culturally-sensitive and respectful way (Finn et al., 2012, p. 206-207).

In their conclusion, Finn et al. (2012) stated "we suggest that clinicians can and must be politically engaged if their dealings with non-exclusive relationships are to not perpetuate the pathologization of open non-monogamies and those involved" (p. 213). Historically, there has been significant pathologization by the mental health field of different expressions of sexuality, including sexual orientation, gender identity, non-monogamy, and also kink - which Pillai-Friedman et al. (2015) defined as a term "used to describe a variety of BDSM practices" (p. 197). Since there is often overlap between the LGBTQIA, non-monogamous, and kink communities (Sprott et al., 2017), we felt it was important to examine and address discussing the topic of kink with clients in the therapeutic setting as part of our review of this literature.

Talk Therapy and Kink.

We found only limited research regarding how BDSM and kink are talked about in talk psychotherapy, despite the increased media and pop culture attention that has been paid to these sexual practices in recent years (Sprott et al., 2017). However, the literature that does exist emphasized the importance for mental health professionals and sexuality professionals to have a

firm understanding of BDSM (Bondage and discipline (B/D), dominant and submissive (D/s), and sadism and masochism (S/M)) (Pillai-Friedman et al., 2015) as well as other kink practices before working with clients who engage in these activities. Researchers pointed out that many therapists may be already seeing clients who are actively engaged in BDSM, while other clients may be curious or may be newly discovering BDSM and kink. And others still may have kink-related fantasies which they have suppressed due to feelings of shame and guilt brought on by social stigma about such desires (Pillai-Friedman et al., 2015, p. 197). Pillai-Friedman et al. (2015) highlighted how BDSM and kink have historically been pathologized by the legal system, law enforcement, employers, feminists, and former editions of the *Diagnostic and Statistical Manual of Mental Disorders*, contributing to clients' feelings of shame or reluctance to disclose this aspect of their sexuality in therapy (p. 198). But Sprott et al. (2017) noted that despite this stigma, a considerable amount of recent research "finds little or no difference in psychological functioning and attachment styles when comparing those who engage in alternative sexualities with controls" (p. 929).

But not all therapists are informed or aware of such research, and many may still hold pathologizing views of kink and BDSM. Pillai-Friedman et al. (2015) noted potential treatment issues which can arise when a therapist lacks knowledge about different kink and BDSM practices that are relevant to their clients. Therapists might feel shock, disgust, or aversion to a client's discussion of these practices, and interpret these sexual behaviors as harmful or self-destructive (p. 200). Pillai-Friedman et al. (2015) and Connan (2010) both identified how therapists' personal values and beliefs regarding sexuality can influence their interpretation of BDSM and kink activities. While therapists should be encouraged to educate themselves on these

subjects in order to better serve their clients, Pillai-Friedman et al. (2015) pointed out that "it is unprofessional to use clients as a resource for learning about BDSM" (p. 204).

Connan (2010) argued that since all clients in the psychotherapeutic setting are unique, their individual practices of BDSM and kink will also be unique - and even when similar behaviors occur, there will be varying definitions from client to client. Pillai-Friedman et al. (2015) echoed this point, adding that just like sexual orientation, kink should not be assumed to be the presenting problem or the source of a client's troubles: "kink-aware therapists are aware that for many of their clients who practice BDSM, it 'is just another facet of the client's life, like their vegetarianism or their hobby of knitting'" (p. 201). The literature on kink, as well as previously-mentioned literature on other aspects of sexuality, has indicated that therapists' comfort levels regarding discussion about sexuality are a significant factor in the quality of the therapeutic environment and alliance (Girard & Brownlee, 2015; Gochros, 1986; Love & Farber, 2017; Magee & Spangaro, 2017; Pillai-Friedman et al., 2015; Timm, 2009; Walters & Spenger, 2016). Therefore, we continue our review of this literature by delving deeper into an exploration of therapist comfort levels regarding conversations around sexuality, to examine their effects, and to explore possible solutions or improvements that can be made to help ease the discomfort many therapists face.

Therapist Comfort Discussing Sexuality.

Much of the research we found that examines therapists' comfort levels regarding discussions of sexuality revealed that feelings of fear or discomfort may be a result of the fact that the majority of the literature, training, and ethical values are based in heteronormative bias (Love & Farber, 2017). Gochros (1986) echoed similar findings, and noted that therapists who

have been raised with values that discouraged open discussion of sex may find it difficult to suddenly make the shift to inviting that open discussion into the therapy session. He observed that talking about sex and sexuality is so societally taboo that many therapists hold the conviction that sex is a private matter, and that asking or "prying" into those areas of the client's life, even in a therapeutic context, would be inappropriate (p. 9).

Gill & Hough (2007) highlighted how the personal beliefs of the therapist can dictate the level of client disclosure by affecting the level of felt safety in the therapeutic environment:

> As professionals, we must be mindful that sexuality can exist under all circumstances within a variety of expressions, some known and some not known. When [the therapist] asks, "how do you feel?" and "May I help you?" make sure to listen with an open mind. (p. 75)

Although this concept of open-mindedness is emphasized throughout the literature, abandoning personal feelings can be difficult when considering sexuality (Gill & Hough, 2007). Gochros (1986) noted that many mental health providers "consider [sexuality] irrelevant to the mission of the profession or the particular job" (p. 8), but he pointed out that this assumption and the avoidance that stems from therapists' own discomfort "results in countless lost opportunities for helpful interventions" (p. 8).

Love & Farber (2017), Harris & Hays (2008), and Paprocki (2014) echoed this idea, and identified a difference between therapist discomfort and impairment or incompetence due to ethical conflict. An ethical conflict could involve a therapist providing inadequate care to a client due to discomfort or avoidance of a conversation about sexuality, even though it may directly relate to the client's primary issues (p. 281). Ethical conflicts or incompetence could be due to an

aversion or bias against members of the LGBTQIA community, clients practicing kink or non-monogamy, or other prejudices regarding sexuality, which could be due to religious beliefs or other cultural values that conflict with what the client is discussing in the session (Paprocki, 2014, p. 280). Love and Farber (2017) discussed a study in which 60% of the therapists sampled either did not ask their clients or asked their clients infrequently about sexual health, and 50% of the therapists sampled reported that their comfort level in discussing client sexuality was influenced by a lack of training on the subject (Reissing & Giulio, 2010).

Much of the research we reviewed offered suggestions to decrease the discomfort therapists may feel when discussing sexual topics with clients (Gill & Hough, 2007; Harris & Hays, 2008; Love & Farber, 2017; Paprocki, 2014). These included: continuing education, completion of training programs regarding sexuality, and supervision and consultation (Gill & Hough, 2007). Harris & Hays (2008) also pointed out that increased comfort with these topics often comes with experience, and they encouraged therapists not to shy away from but to continue to gain experience working with clients dealing with sexual issues or discussing sexuality in treatment (p. 286). In addition to seeking to understand the therapists' perspectives and comfort levels when it comes to discussion of sexuality in therapy, we also felt that it was important to explore clients' experiences of disclosure in therapy, and what makes them more or less likely to disclose or initiate these conversations.

Client Disclosure and Sexuality.

When considering disclosing their sexual orientation, gender identity, or any other aspects of themselves related to sex and sexuality, clients may fear what their therapist's reaction will be (Baumann & Hill, 2016; Love & Farber, 2017; Magee & Spangaro, 2017; Sprott et al.,

2017) We reviewed literature on the subject of client disclosure in therapy in order to explore how this affects the therapeutic experience, and to identify possible reasons why clients choose to disclose or not disclose. Much of the research regarding client disclosure of sexuality addressed how important and pertinent this aspect is to the therapeutic process: Harris & Hays (2008) emphasized the importance of sexual conversations in therapy, particularly since those conversations often cannot happen in other places in society. The researchers noted that having a place where they can be honest and express their sexuality can be beneficial to clients because "how individuals feel about their sexuality will greatly affect their general-self image and confidence" (Harris & Hays, 2008, p. 240).

Both Love & Farber (2017) and Harris & Hays (2008) emphasized how both American culture and avoidant or ambivalent behavior from the therapist around the topics of sex and sexuality can take the form of implicit signals that minimize the importance of these topics, and convey to the client that they do not need to be discussed in great length in the therapeutic setting. Love & Farber (2017) stated "the ways in which therapists approach the topic of sex can facilitate the conversation or shut it down" (p. 1490). The researchers went on to note that "about half of our subsample indicated they would be more open if the therapist directly asked them about sexual material… [however], 40% described needing to trust the therapist more or to be assured that disclosure would not ruin the therapeutic relationship" (Love & Farber, 2017, p. 1494). Walters & Spengler reiterated this idea in reference to client disclosure about pornography use, reporting that while open-ended questions may be less effective with clients, closed-ended questions may help clients feel a sense of safety, encouraging more honesty in their answers (p. 354-355). Similar results were also found by Paprocki (2014) and Cerbone (2017).

A study by Bauman & Hill (2016) found that the secrets participants most commonly concealed in therapy were those regarding relationships or sexuality (p. 61). This study also identified that the most common reason clients cited for concealing a secret about sexuality was shame or embarrassment, especially if their sexual practices were not normative and could be considered "objectionable" (p. 61, 68). Additionally, those clients who concealed secrets related to sexuality reported that they considered their relationships with their therapists to be weaker (Bauman & Hill, 2016, p. 66). Because discomfort can be present on both sides of the therapeutic alliance, and both therapist and client are susceptible to societal stigma and shame regarding sexuality, verbal means of communication may not always be the most beneficial for these conversations. Therefore, our review of this literature brought us to research from the field of art therapy, wherein we explored how art therapy is used to facilitate conversations about topics of sex and sexuality that clients may struggle to put into words.

Art Therapy

Art therapy builds upon the ideas of traditional talk therapy, and incorporates visual imagery and tactile media to help clients express their thoughts and feelings in a space where they might feel empowered and less anxious to talk about sexual topics (Metzl, 2017). Rubin (2016) emphasized the collaborative nature of this form of therapy, as the client might be the one making the artwork, but the "therapist and patient work together toward understanding" (p. 74) and that understanding of the artwork is guided by the client. Betensky (1977) explained that the process of art-making offers clients a chance to explore thoughts and feelings in a way that can lead to greater self-discovery (p. 175). She noted that abstraction and symbolism in the artwork "renders the presented phenomenon anonymous," (p. 178) providing the client with a way to

express thoughts and feelings that they may not be ready to talk about explicitly until a greater level of trust and rapport is developed with the therapist. Yet the very act of making the art may facilitate disclosure and discussion of these thoughts, as "the patient volunteers hints and bits of information to the therapist in order to individualize or concretize some of the anonymous abstraction" (Betensky, 1977, p. 178).

It is powerful effects of art therapy such as these that inspired much of the research and literature in the field. Junge chronicled the origins and history of art therapy in her book *The Modern History of Art Therapy in the United States* (2010). She explained that art therapy emerged as a profession in the United States in the first half of the twentieth century, following on the work of earlier psychologists and psychiatrists who were fascinated by the art made by psychiatric patients (Junge, 2010, p. 5-6). Many of the earliest pioneers and practitioners of art therapy, as well as those who were influenced by them and came after them, published books and articles attempting to explain and define art therapy in their own words. Wadeson (1987) described art therapy thus: "although art therapy is both an art and therapy, it is more" (p. 1). And Betensky (1977) elaborated on what that "more" might be, describing how the phenomenological process of art therapy could lead the client to "a sense of new clarity and to an awareness of heightened consciousness" (p. 179).

Much of what has been written about the role of the art therapist emphasized that the therapist collaborates with the client to explore and identify the meaning in the client's artwork. Rubin (2016) offered a reminder that:

> Contrary to the popular caricature of the analytic art therapist arbitrarily imposing meaning on the patient or the art, the method is in fact highly

> respectful, and the goal is always to help the patient make his or her own discoveries or "interpretations." (p. 75)

Additionally, Wadeson (1987) pointed out that some details in the client's drawings may not make sense to the therapist, or the therapist might make the wrong interpretation of them, unless the client explains what they are (p. 78-79). Betensky (1977) observed that a symbol could be a client's "secret hiding self" (p. 178) but also pointed out that a symbol could have multiple meanings. Landgarten (1981) echoed this, and noted that understanding what a symbol means to one client should not lead to assumptions about its use by other clients, as the same object or symbol might have very different meanings to different people (p. 4). While some art therapists yearn to identify patterns and consistent meanings of symbolism in client art, so that understanding the images might be a mere matter of decoding the symbols, Wadeson (1987) warned that research has not shown this to be reliable or useful (p. 101).

Art therapy's ability to offer clients a means of nonverbal communication may also help individuals express thoughts and feelings they are not consciously aware of yet. Freud (1965) viewed dreams as insight into unconscious thoughts and desires, but he recognized that the imagery and sensation one experiences while dreaming was not so easily put into words: "I could draw it', a dreamer often says to us, 'but I don't know how to say it'," (p. 90). This particular passage from Freud's lectures has been quoted by multiple art therapists, including Wadeson (2010), who went on to explain that art therapy is such a powerful form of nonverbal expression because it is innate to us as humans: "We think in images. We thought in images before we had words" (p. 9).

Much of the research on the effectiveness of art therapy emphasizes its ability to help clients express things they either could not or did not want to put into words. Junge (2010) noted that art therapy is an extension of Freud's theories about the unconscious, as art-making is able to "sidetrack defenses" (p. 10) and reveal unconscious thoughts and desires. Wadeson (2010) observed that "unexpected things may burst forth in a picture or sculpture, sometimes totally contrary to the intentions of its creator" (p. 11) and explained that clients may be surprised to see they have created something they did not set out to, but may later come to understand that it was something they needed to talk about.

Using Art to Explore Sex and Sexuality.

Such personal expression through art-making is not unique to art therapy, but has been used by artists throughout history before art therapy emerged as its own field. Among the many topics that artists have explored throughout the history of art as we know it, sex and sexuality stand out as prominent subjects. And artists have used their artwork to express thoughts and feelings about both their own sexuality and the sexual values of their cultures and societies (Kampen, 1996; Lucie-Smith, 1991; Reed, 2011; Turner, 2017). Lucie-Smith (1991) explored the appearance of sexual imagery in artwork from ancient times to the modern age, and noted that Paleolithic works such as the famous Venus of Willendorf emphasized (and exaggerated) sexual parts of human anatomy, possibly suggesting messages about fertility. And Turner (2017) examined sexual imagery depicting gender fluidity and bisexuality in Graeco-Roman sculptures that featured both male and female genitals and secondary sex characteristics (p. 272-273). In the medieval era, although sexuality became more suppressed by the dominant religion of Christianity, it was still depicted in art. Lucie-Smith (1991) noted the visible dichotomy between

that suppression and desire, as "Christian fear of sex, and contempt for the body, are frequently expressed in a way that graphically expresses the attractions of what was feared and desired" (p. 34). He continued looking at sexual imagery in artwork through the twentieth century, including works such as Robert Mapplethorpe's photographs, which shocked viewers with their explicit exploration of homosexuality, sado-masochism, and race (p. 266-270).

While a great deal of the expression of sexuality in artwork was overt, Lucie-Smith (1991) also examined the use of symbolism in art throughout history. He identified certain images such as knives and snakes which appeared to be used as phallic symbols in some contexts (p. 239-240). Kampen (1996) examined ideas about gender and gender fluidity in ancient art that were also conveyed symbolically, through characters of one gender wearing the clothing of the other gender (p. 243). Symbolic representation of ideas about sexuality continued into the modern era, and Reed's (2011) examination of homosexual imagery in artwork throughout history noted that many artists in the modernist movement of the early twentieth century used "coded communication" in abstract imagery to convey ideas about sexuality and same-sex attraction which were secrets the artists could not openly share at the time (p. 127-128). Reed observed that later in the 1980's, during the AIDS crisis, avant garde artists became much more open about homosexuality in their work (p. 208), and art became a form of activism, perhaps best represented by the NAMES Project AIDS Memorial Quilt, a large-scale community art project that brought awareness to the pandemic (p. 215-216).

Art Therapy and Sexuality.

Seeing how sexuality and art have historically gone hand-in-hand with each other, it seems both natural and logical that art therapy should be an ideal modality for exploring

sexuality (Metzl, 2017; Pelton-Sweet & Sherry, 2008). However, there is limited research on the use of art therapy to help clients talk about sex and sexuality. While there is a great deal of research and theory on the use of art therapy with children who are the victims of child sexual abuse, there is less research on the use of art therapy with adults who have experienced sexual assault, and even less research on using art to explore other aspects of sex and sexuality not limited to sexual trauma. Within the small amount of existing research, there appears to be a focus on the use of art therapy with several populations: the LGBTQIA community (Addison, 1996; Brody, 1996; Ellis, 2007; Pelton-Sweet & Sherry, 2008) - with select research specifically focusing on the transgender community (Barbee, 2002; Beaumont, 2012; Piccirillo, 1996; Zappa, 2017), clients dealing with sexual problems such as sex addiction (Fischer & Wilson, 2018; Wilson, 1999), and survivors of sexual assault (Brooke, 1995; Hargrave-Nykaza, 1994; Metzl, 2017). There is also a small but growing amount of research focusing on incorporating art therapy into sex therapy practices (Barth and Kinder, 1985; Kahn, 2013; Metzl, 2017).

Art Therapy with LGBTQIA Clients.

Much of the research on the use of art therapy with LGBTQIA populations has focused on using art to help clients express their sexual identity (Brody, 1996; Hogan, 2002; Pelton-Sweet & Sherry, 2008). Brody (1996) wrote about an art therapy support group for low-income lesbian clients experiencing isolation, and observed that the art-making proved more helpful than talk therapy when it came to increasing group cohesion (p. 29). Brody's group utilized a variety of two-dimensional and three-dimensional art materials, but she noted the importance of including "lesbian as well as mainstream magazines for collage" (p. 23), providing her clients with materials that acknowledged their own culture. Addison (1996) further explained

how art materials themselves can be LGBTQIA-affirmative, recounting how including LGBTQIA magazines in the collage materials offered to clients helped one client talk about his sexuality in group therapy for the first time, opening up about struggles which he had not disclosed before (p. 54). Pelton-Sweet & Sherry (2008) also examined how art therapy can help clients in the coming out process, and identified directives such as self-portraits and depicting the "publicly presented self" in contrast with the "private, internal, self" which allowed clients to express feelings they may not have been able to verbalize (p. 173).

Much of the research we reviewed noted that affirmative art therapists should be aware of symbols commonly used by the LGBTQIA community, such as "pink triangles, rainbow flags, and freedom rings" (Addison, 1996, p. 55) so they can engage in conversation with the client about these symbols if they appear in the artwork. Hogan (2002) pointed out that sometimes these LGBTQIA symbols appear in clients' artwork as subtle "clues" (p. 60). And these clues may not be limited to flags and other geometric symbols, but might include images of celebrities who are considered icons for the LGBTQIA community, such as Ellen DeGeneres, Elton John, Judy Garland, and others (Hogan, 2002, p. 61). It is important for the affirmative art therapist to both provide materials that include or allow clients to express their sexuality, and to have some background knowledge to help them understand what that sexuality might look like when represented through symbols (Hogan, 2002).

Despite the emphasis in the art therapy literature on making art therapy LGBTQIA-affirmative, the literature concerning art therapy with this population is still limited. Ellis (2007) noted the lack of previous research on the use of art therapy to explore sexuality when she presented her findings from art therapy work she did in a workshop with female clients

exploring their sexualities. In this workshop, art making proved useful to clients in overcoming taboos about discussing sex. Ellis stated "since for the client, talking about sexuality may feel embarrassing and exposing ... artwork may offer more safety for such exploration" (p. 65). She also pointed out the importance of understanding the clients' cultural contexts beyond their sexual identity alone, including racial and ethnic identity, socioeconomic status, and others.

Within the art therapy research related to LGBTQIA clients, a significant percentage is devoted specifically to transgender and gender-independent clients (Barbee, 2002; Beaumont, 2012; Piccirillo, 1996; Zappa, 2017). In a case study of three transgender men who had AIDS, Piccirillo (1996) found that making art allowed the clients to explore and experiment with appearance and identity. Piccirillo noted the power of visual expression because "art, like the body, is the self made physical" (p. 45). Similarly, Barbee (2002) conducted a study with transgender clients in San Francisco, in which participants were given the art directive to show "how you see the story of your gender identity" (p. 55) using disposable film cameras. The purpose of this study was to gain a greater understanding of how transgender clients view their gender identities, and how art can help them explore those identities, especially as they progress in the transition of making their physical appearance congruent with their gender. It is particularly noteworthy that Barbee's goal for this research was to help educate other clinicians about the experiences of the transgender community, and he points out that this was an important incentive for participants to be involved in the research (p. 56). Much of the terminology in Barbee's research is outdated, but the use of art making to explore one's gender narrative is a concept that is still relevant in art therapy today.

In more recent research, Beaumont (2012) argued for a "compassion-oriented art therapy" model when working with transgender clients, to "increase clients' self-compassion, and thus, reduce shame and self-criticism, which may foster the resilience that is needed for living as a gender-variant person in today's society" (p. 4). Beaumont cited examples of art directives that have been used to help clients explore gender expression, including self portraits, "the bridge drawing" (Hays & Lyons, 1981, p. 208), drawing a "safe place," and directives exploring the ideas of a "compassionate self" contrasted with a "self-critic" (Beaumont, 2012, p. 3). Beaumont also identified specific media such as photography and collage, echoing other researchers who have also identified these media as particularly helpful for exploration of sexuality and gender identity. Zappa (2017) made an argument for increased cultural competency among art therapists working with transgender and non-binary populations, and reviewed older art therapy research, including Piccirillo's article (Piccirillo, 1996), in which she identified common problems of "misgendering, erasure, and pathologization" in the researcher's methods and language (Zappa, 2017, p. 131). Zappa also pointed out that the reliance of most research on case studies does not accurately "represent the diversity of trans and gender-independent people" (p. 132).

Art Therapy with Clients Experiencing Sexual Issues.

Fink and Levick (1973) found through their research with clients who disclosed sexual problems that "art production is less guarded and is produced with less inhibition or guilt arousal than spoken words might be" (p. 277). The clients profiled in their research expressed shame and fear related to sexual issues ranging from masturbation to abortion, but were able to discuss these concerns in therapy after creating art about them. In a study researching the use of art therapy

with both LGBTQIA clients and the partners of sex addicts, Cowley, Gallop, & Feinberg (2016) found that "all participants used a large amount of space in their art responses, potentially also showing a strong engagement with the art and hence, showing it useful in exploring sexuality" (p. 106). The researchers also noted the potential for art making to allow a way for clients to get around defenses that might prevent them from verbally discussing topics related to sex and sexuality. Other topics related to sexuality which have been addressed in art therapy include clients' conflicting feelings about being both a parent and a sexual being. Hogan's (2012) case study of a client who had recently given birth showed how the process of making art allowed the mother to bring up feelings about her sexuality which might have been difficult to express verbally (p. 317-318). Another sexual issue clients may address in art therapy is that of sexually transmitted diseases. Although the prevalence of STDs in the United States would suggest that many therapists might see clients dealing with such issues, the only art therapy research we found on this topic was Metzl's (2017) case study of a woman who had contracted herpes. This case study demonstrated the benefits of using art therapy to explore such a topic, as the subject identified art as "the only thing that helped" in her expression and processing of the stigma and shame surrounding the STD (p. 76-77).

Much of the art therapy research on sexual issues not specific to sexual minorities has centered around sex addiction. Through case studies with clients dealing with sex addiction, Wilson (1999) identified that art therapy's ability to "make the invisible, visible" (p. 10) provided clients with a way to reveal addictions they had been keeping secret for years, and to explore what that secrecy and addiction meant to them. Wilson made note of the fact that therapists must be aware of their own biases when it comes to working with such populations,

considering how graphic the imagery in the clients' artwork may be. But she also noted that some clients felt obliged to ask for her permission before creating graphic depictions, emphasizing the importance of creating a nonjudgmental therapeutic environment in which clients can openly express themselves. In a more recent study, Fischer & Wilson (2018) compared the effectiveness of an art therapy approach with a cognitive-behavioral therapy approach for reducing feelings of shame among clients exhibiting hypersexual behaviors, and found the two forms of therapy equally effective. The researchers suggested that this could be due in part to art therapy's ability to invoke unconscious thoughts and create a safe space for clients to explore their feelings.

Art Therapy with Survivors of Sexual Assault.

Although as previously stated, most of the research on the use of art therapy with survivors of sexual assault focuses on victims of child sexual abuse, the limited research available on adult survivors of sexual assault suggests that art therapy is equally helpful with this population. There is also a large amount of research on the use of art therapy as treatment for other types of trauma, which may also support its use in treatment with survivors of sexual assault. Hargrave-Nykaza's (1994) research included a case study of an artist creating art in response to being sexually assaulted. Although this was not done in the context of art therapy, Hargrave-Nykaza noted how the art making and use of symbols in the artwork helped the artist work through feelings of shame, stigma, and loss of control.

A study done by Brooke in 1995 showed that art therapy measurably improved the self-esteem of survivors of sexual assault in group therapy. Brooke identified specific ways in which art therapy was beneficial to this population, including boosting their confidence, giving

them a coping mechanism, and providing a "safe outlet for emotions" (p. 453). Metzl (2017) likewise found that art therapy was containing and created a sense of safety in a case study of an adult client in trauma treatment for childhood sexual abuse. The use of art as opposed to purely verbal processing allowed the client to express feelings and somatic responses that the client may not have been able to put into words (p. 105-109).

Art Therapy and Sex Therapy.

Barth and Kinder (1985) reviewed art therapy directives that have been used in marital and sex therapy, including "the Joint Picture exercise" and "the Joint Scribble technique" (p. 193), as well as the Draw A Person test (p. 194). The researchers noted the usefulness of art making to allow clients to express thoughts and feelings about topics that they might have difficulty talking about, such as sex. Kahn (2013) interviewed practicing therapists about how they integrate art therapy and sex therapy in their work with clients, and found that her subjects reported using specific art directives such as coloring body parts, and including "sexually suggestive images" in collage materials provided to clients (p. 47). But the art therapists she interviewed also revealed that they were less likely to bring up the subject of sexuality unless a client brought it up first, in contrast with the sex therapist who asked clients direct questions about sex and sexuality. Metzl's (2017) research echoed this, as a survey of alumni from Loyola Marymount University's Art Therapy program revealed that most graduates practicing as therapists were not using art making to help clients explore their sexuality (p. 91).

Metzl identified many populations and issues for which art therapy combined with sex therapy creates a particularly powerful mode of treatment. Looking at art therapy through this lens, Metzl's case studies span a range of clients, ranging from those struggling with the stigma

of sexually transmitted disease to those exploring feelings about their gender. She cited art making as a way to not only help clients process feelings of shame surrounding their sexuality, feelings which may be difficult to put into words, but also as a means of containment, creating a holding space for those thoughts and feelings (p. 76-77). Through her work with clients seeking sex therapy, Metzl discovered a parallel between clients' anxiety about their sexual issues and their anxiety about the prospect of art therapy: "they are both linked to performance!" (p. 131). She noted that in these cases, making art "allows clients to work thoroughly and symbolically through performance issues long before a direct goal of performing any kind of sex comes up in the discussion" (p. 131). And for clients struggling with negative feelings surrounding sexuality, Metzl noted that "when fear and shame are at the heart of how we have learned to cope with sexuality and intimacy-related issues, the words are hard to come by" (p. 83), which is where the art can be so useful and powerful.

Conclusions

In this literature review, we examined research from both the field of talk therapy and the field of art therapy, exploring how client discussion of sexuality in treatment can be difficult, and ways in which therapists can help facilitate such disclosure. The literature revealed that there are recommended techniques as to how we can improve ourselves as therapists and create a space for our clients to be forthcoming about their sexuality and sex practices. And art therapy's ability to help clients disclose unconscious desires or thoughts and feelings that are difficult to talk about can be beneficial to assisting clients exploring sex and sexuality in therapy, but the research on this is limited, and there is a strong need for considerable more research and investigation to explore this potential.

Recommendations

It is understandable that much of the research in the field of art therapy addressing sexuality has focused on clients presenting with sexual problems (Fink and Levick, 1973; Fischer & Wilson, 2018; Metzl, 2017; Wilson, 1999) or clients who identify as sexual minorities (Barbee, 2002; Beaumont, 2012; Brody, 1996; Piccirillo, 1996) since many art therapists are keen to help clients with their presenting problems, and passionate about working with underserved populations. But there is a risk that this might suggest to some art therapists that if their clients do not present with problems related to sexuality, or if their clients do not identify as sexual minorities, then there is no need to use art to explore sexuality in treatment. And since sexuality is a significant part of most humans' lives, this would be a considerable missed opportunity. Furthermore, as the research in both talk therapy and art therapy has shown, social factors such as shame and stigma contribute to client reluctance to disclose issues of sexuality in therapy (Gochros, 1986; Love & Farber, 2017; Metzl, 2017; Pukall, 2009), so there is the potential for valuable research to be done on the use of art therapy explorations of sexuality with wider populations, including those clients who do not immediately bring up topics related to sex or sexuality in session.

It is also evident from Kahn (2013) and Metzl's (2017) research that students graduating from Art Therapy programs are hesitant to address sexuality in treatment, both verbally and through the art making process. Considering what a valuable tool art can be in discussing sexuality with clients, it seems that graduate programs could provide more specific training both on sexuality itself in treatment, and how art therapists can use art-making to talk about sex in therapy. Further research surveying a wider population of graduates, including those from

different schools, would be useful, as would research identifying how different art therapy programs address sexuality in their curriculum.

Methods

Definition of Terms

Asexual: Having little sexual desire or no sexual desire at all. (Steelman & Hertlein, 2016).

BDSM: Bondage and discipline (B/D), dominant and submissive (D/s), and sadism and masochism (S/M) (Pillai-Friedman, Pollitt, & Castaldo, 2015).

Bisexual: Being sexually attracted to both sexes (men and women) (Hogan, 2012, p. 57).

Cisgender: The sense that one's "personal identity and gender correspond to biological sex" (Zappa, 2017, p. 129).

Gay: A man who is sexually attracted to other men (Hogan, 2012, p. 57).

Gender: Sing, Boyd, & Whitman (2010) report that "*gender* is defined by society and reflects the social norms of what is considered to be feminine and masculine" (p. 416).

Gender-independent: Not identifying as either male or female. Zappa (2017) suggests the use of this term "to avoid suggesting that there is a standard gender to which people need to conform. . . . to include people who are gender nonconforming, as well as people with other nonbinary gender identities and expressions" (p. 129).

Heterosexism: "this term was created as an alternative to the more common term 'homophobia,' in order to highlight the similarities between the oppression between lesbian, gay, and bisexual persons, and the oppression of women and people of color...it refers to a systematic process that simultaneously grants privileges to heterosexuals and oppress LGB persons" (McGeorge, C. & Carlson T.S., 2011).

Intersex: Individuals whose biology is such that they "cannot easily be categorized as male or female" (Singh, Boyd, & Whitman, 2010, p. 417) due to anatomical or chromosomal

variations.

Kink: Pillai-Friedman, Pollitt, & Castaldo (2015) stated that "the terms kink and kinky sex are often used to describe a variety of BDSM practices" as well as the culture around these practices (p. 197-198).

Lesbian: A woman who is sexually attracted to other women (Hogan, 2012, p. 57).

LGBTQIA: Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual

Monogamy: According to Merriam-Webster, monogamy is defined as the state or custom of being married to only one person at a time

Non-monogamy: According to Merriam-Webster, non-monogamy is defined as not of, relating to, or practicing monogamy. (Nonmonogamous, n.d.)

Polyamory: a term used to describe relationship models wherein individuals pursue multiple concurrent romantic relationships with the permission of their partners (McCoy, Stinson, Ross, & Hjelmstad, 2015).

Queer: According to Vanderbilt University ("Definitions," n.d.), queer is defined as a sexual orientation which advocates breaking binary thinking and seeing both sexual orientation and gender identity as potentially fluid. The term is a simple label to explain a complex set of sexual behaviors and desires. For example, a person who is attracted to multiple genders may identify as queer. Many older LGBT people feel the word has been hatefully used against them for too long and are reluctant to embrace it. "Queer" can be used as an umbrella term to refer to all LGBTQIA individuals.

Sex: "The physiological determinants of 'male' and 'female'," (Singh, Boyd, & Whitman, 2010).

Sexual Orientation: One's "emotional, romantic, or sexual attraction to persons of a particular

sex" (Hogan, 2012, p. 57). Hogan (2012) notes that sexual orientation is not something that one chooses, and it can be harmful to attempt to "change" a person's sexual orientation (p. 57).

Transgender: Singh, Boyd, & Whitman define *transgender* as "an umbrella term that refers to individuals whose gender identity transgresses traditional definitions of 'male' and female'. Many of these individuals experience themselves as a gender other than the one to which they have been assigned" (p. 417).

Research Approach

Our research utilized a mixed methods approach to explore practicing art therapists' understanding of their work with clients discussing sexuality in sessions. We used both quantitative and qualitative methods to gather data through an online Qualtrics survey, and we used qualitative methods to gather data from an interview which included semi-structured interview questions as well as participant art-making. Since we anticipated that we would be able to reach a larger number of subjects through the online Qualtrics survey, we hoped that the data collected through this method would allow us to statistically analyze art therapists' experiences regarding discussion of sex and sexuality with clients. This statistical data would help us concretely identify trends and patterns in participants' responses by comparing them to previous research, as well as highlighting newfound information. This data would also inform us and prepare us to delve deeper into themes we observed in the data, and following the survey with the interview as our next step in the research process would help lead us to a more in depth understanding of art therapists' experiences. The semi-structured format of the interview was designed to allow the interview participant to elaborate further upon these topics, leading to

further conversation and discovery. Inviting participants in both the survey and the interview to create art was also intended to provide greater depth of information by exploring art therapists' experiences non-verbally.

Creswell & Creswell (2018) noted that mixed methods research is often chosen as a research approach because utilizing both qualitative and quantitative methods can provide a deeper, multifaceted understanding of the research questions, and can also potentially reduce some of the limitations that would be present if only one method was used on its own (p. 216). A further advantage of this methodology is that it allows for the participants' personal experiences to be included in the research collection along with quantitative data (p. 228). The findings of both the qualitative and quantitative methods can be compared and analyzed together to identify and interpret the results of a study, as qualitative data builds upon the quantitative data by explaining its findings in more detail (p. 241).

Elkins & Deaver's (2015) survey for the American Art Therapy Association's (AATA) Membership Survey Report utilized a survey method to collect data from AATA members. Elkins & Deaver noted that using a survey method allowed them to research demographics, and gave them the ability to see a general view or a detailed description of the survey questions presented. Additionally, Elkins & Deaver stated that survey methods research provides the ability to examine change over time. Therefore, if researchers desire to do longitudinal work, the researchers can ask the same survey questions in future research, allowing them to compare and contrast responses from different years.

Asawa's (2009) study of art therapists' emotional reactions to technology utilized three focus groups to collect data from participants. Asawa noted that her choice of focus groups was

motivated by the knowledge that they would provide a great deal of data, and that they are also "stimulating for respondents" (p. 60). These focus groups also utilized art-making, and Asawa found that discussion among the participants as they viewed each others' artwork was another valuable source of data. Analyzing the data after the study was completed, Asawa was able to identify themes that emerged from the artwork and the discussions, and further identify specific nuances and emotional responses within these themes. Although we ultimately were unable to hold a focus group, we hoped that our semi-structured interview was similarly stimulating for the interview participant.

Design of Study

Sampling.

Sampling in this research was conducted in two phases: First, the study began with the creation of a quantitative survey that was disseminated to art therapy alumni. The survey requested responses from alumni who have graduated from Loyola Marymount University's Marital and Family Therapy and Art Therapy program and are currently practicing art therapists. The second phase asked survey participants to indicate if they would like to be a part of a focus group that would explore how sexuality is approached in therapy using a semi structured interview format as well as data gathered from art making. Subjects in this study were all practicing art therapists who were willing to discuss their experiences with clients exploring sex, sexuality, and sexual identity in therapy. All subjects were over the age of 18, and although we did not ask participants to identify their ages, we anticipated a wide range in ages, depending on the age at which subjects entered the field. We had hoped to recruit 20-25 participants for the

Qualtrics online survey and approximately 6 - 12 subjects for the focus group. Potential subjects were recruited through the LMU MFT department's alumni email list.

It was likely that subjects recruited through this method would be primarily located in the areas of Los Angeles and Southern California, although it was also possible that some alumni who have relocated to other states may have also chosen to participate in the Qualtrics survey. Thus, one of the limitations to this sample population was that it was potentially restricted to a specific geographic region, and may not have included the experiences of art therapists living in other parts of the United States. Furthermore, an inherent limitation was also the fact that the participants all graduated from the same art therapy program, thus excluding views and experiences of practicing art therapists who received different training and education. An additional limitation to this population was the small sample size, due to the limited number of art therapists that our call for participants reached, which was further limited by the availability and willingness of interested participants.

Gathering of Data.

The email sent to recruit subjects included a link to an online Qualtrics survey. This survey include an informed consent form, the Participant Bill of Rights, and an anonymous questionnaire consisting of 13 questions total. The survey included both likert scale questions and open-ended questions about the subjects' experiences working with clients exploring sexuality through art therapy, as well as a question about subjects' demographics and cultural affiliations. Additionally, the survey included an optional art directive inviting respondents to create a piece of art using materials of their choice and/or available materials, which were asked to upload an image of through Qualtrics. The art directive asked subjects to create a piece of art

that showed what their experience of discussing topics of sex, sexual identity, and sexuality in session with clients is like. At the end of the questionnaire, subjects were be given the option to indicate if they would be interested in participating in a focus group at a later date.

Subjects who indicated their interest in participating in the focus group were contacted through email to schedule a date and time for the focus group. The focus group was intended to be held at LMU in the Marital and Family Therapy department suite on a date and time determined to be convenient based on our availability and that of the subjects. Due to limited interest and availability from participants, we were unable to hold a focus group with multiple participants, but instead conducted an interview with one participant via Skype video. The interview consisted of 11 semi-structured interview questions and an art response. The art directive invited the interview participant to utilize available art materials to create a piece of art that showed how they see art therapy as creating a space for clients to open up about sex, sexuality, and sexual identity. After the participant created their artwork, they were invited to share and discuss the art. The interview was audio recorded, and the interview participant signed a written consent form giving permission for the recording of audio.

Analysis of Data.

Quantitative data collected from the Qualtrics online survey was analyzed using Qualtrics software. Qualitative survey questions that were open-ended questions were examined in order to uncover trends in participants' responses. Qualitative data collected from the interview in the form of observations, audio recordings of participant responses, and participant art was evaluated through the lens of our research questions, with an emphasis themes, content, and art imagery. We triangulated this qualitative data with the quantitative data from the survey to further

investigate themes and other findings. The artwork created in the survey and the interview was analyzed both for content and formal elements such as shape, texture, line quality, color and use of space. Discussion about the artwork that emerged from the interview was also incorporated into this analysis. In addition, we identified emergent findings in the data through the use of tables and graphs to illustrate the statistical prevalence of different themes.

Results

Presentation of Research Data

Our research included mixed methods, collecting data through both qualitative and quantitative methods. The data was collected through two sources: one online survey and one interview. Both of these methods included an optional art response for participants. The participants in both the survey and the interview were practicing art therapists recruited from Loyola Marymount University's Marital & Family Therapy department's alumni mailing list. Our original intent was to invite art therapists to participate in an in-person focus group. But due to issues with scheduling and availability, we were unable to recruit enough participants for a focus group, and instead held an interview with one individual participant. Our data is presented below in the following order: results from the survey, broken down by question type, followed by results from the interview.

Survey.

An invitation to participate in the survey was emailed to the Loyola Marymount University Department of Marital and Family Therapy and Art Therapy's alumni mailing list. The email invited practicing art therapists who have experience working with clients discussing and exploring sexuality, sexual identity, and other topics related to sex, to respond to a survey in which they could share their experiences working with such clients. The email included a link through which interested participants could access a Qualtrics survey which was open for a period of two weeks, and was accessible on both desktop internet browsers and mobile internet browsers. The survey received 11 responses total within those two weeks. The survey consisted of 13 questions (see Appendix F), with an optional Question #12 consisting of an art response,

and an optional Question #13 asking participants if they would be interested in participating in a focus group to be held at a later date.

Likert Question Responses.

Questions #1 - 4 (see Tables 1 - 4) asked participants to indicate their own comfort level and experience discussing sexuality with clients, in particular asking about experience level and comfort level pertaining to specific topics and sexual identities, using likert scales. 11 participants responded to each of these four questions:

> *Question #1: Overall, what is your comfort level with discussion of sex and sexuality in sessions with clients? 0 being uncomfortable, to 5 being very comfortable.*

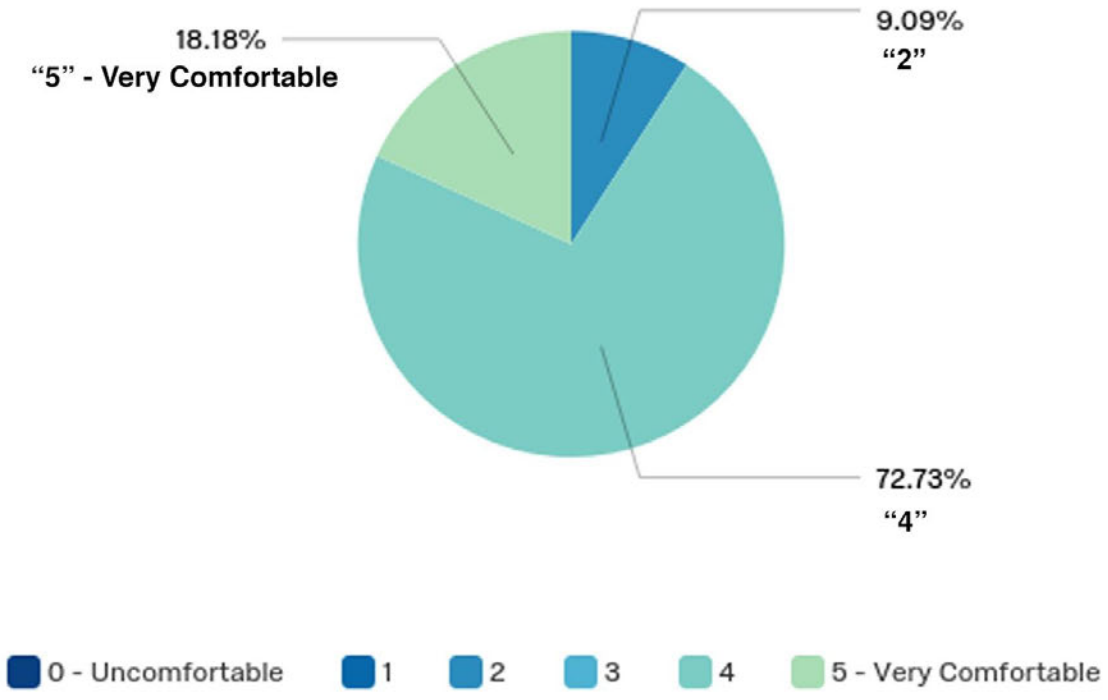

Table 1: Graph of data from Question #1

Table 1 shows that the majority of survey participants reported a comfort level of "4" when discussing sex and sexuality in sessions with clients.

Question #2: To what degree do you have experience talking about the following topics related to sex and sexuality in sessions with clients? 0 being not at all, to 5 being very experienced/expert.

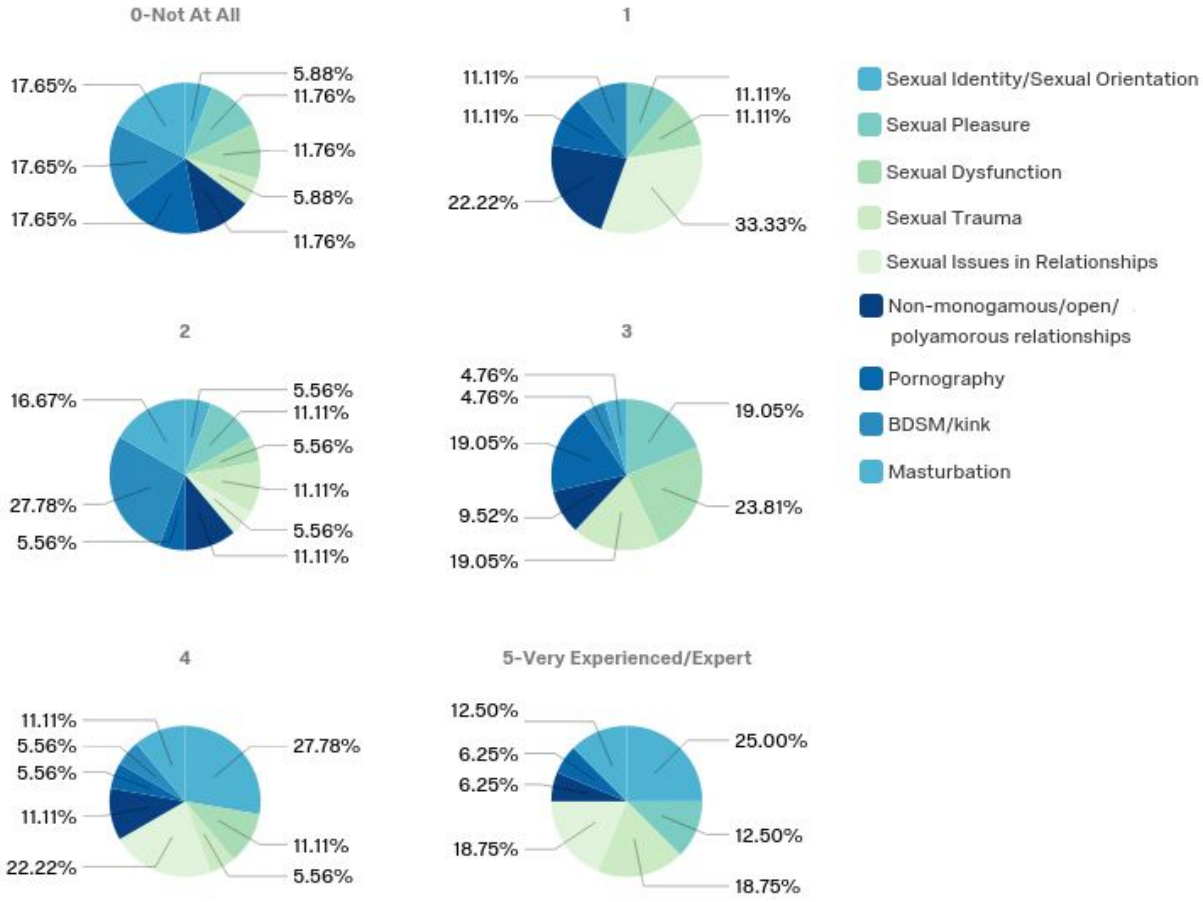

Table 2: Graphs of data from Question #2

Table 2 shows the majority of survey participants chose an experience level of "0 - not at all," when it comes to talking about the topics of pornography, BDSM/kink, or masturbation with clients. The majority of participants reported an experience level of "1" regarding discussion of sexual issues in relationships; a "2" regarding talking about BDSM/kink; and a "3" regarding talking about sexual dysfunction. And the majority of participants reported both experience levels of "4" and "5- very experienced/expert" regarding discussion of sexual identity/sexual orientation.

Question #3: To what degree are you comfortable talking about the following topics related to sex and sexuality in sessions with clients? 0 being not at all, to 5 being very comfortable.

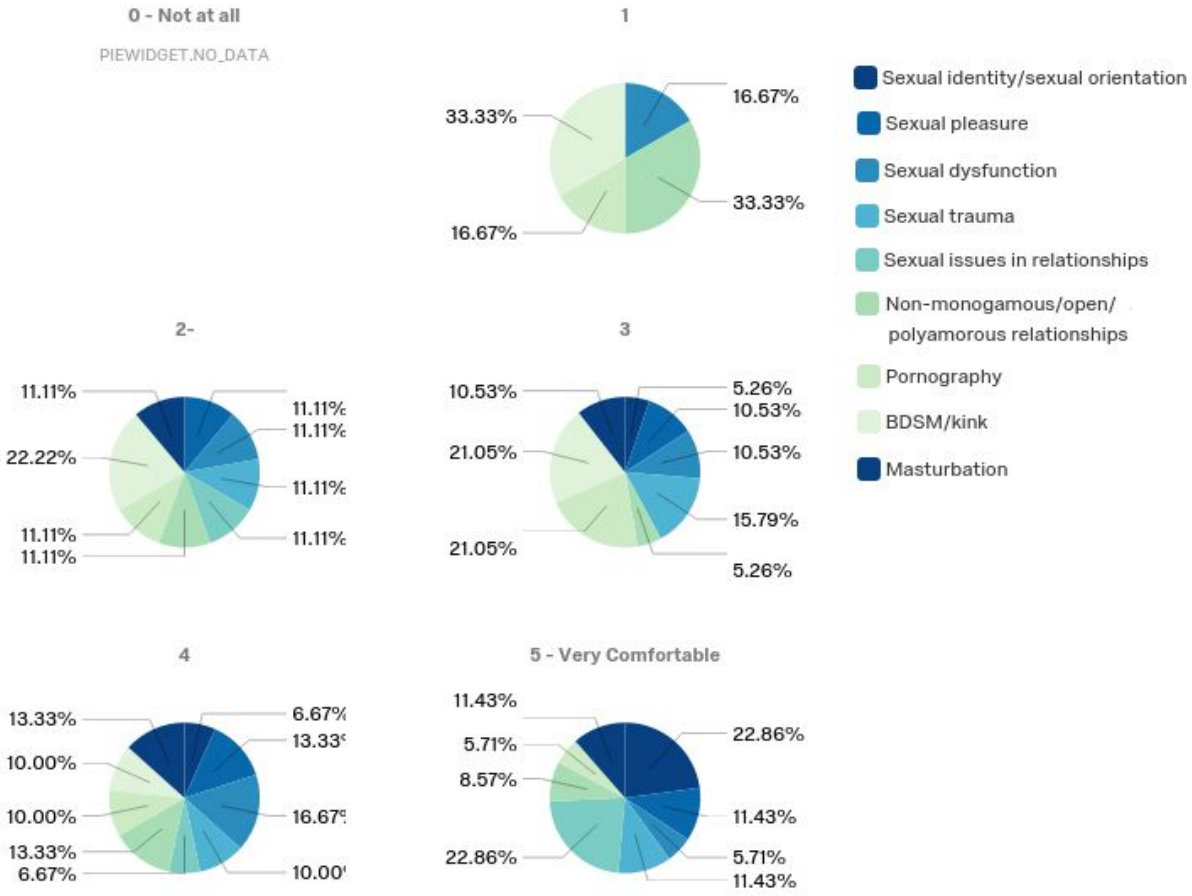

Table 3: Graphs of data from Question #3

Table 3 shows that the majority of participants reported the lowest comfort levels when it comes to talking about non-monogamous relationships and BDSM/kink with clients. The majority of participants reported higher comfort levels regarding discussions of sexual identity/sexual orientation in session with clients.

Question #4: To what degree do you have experience working with clients who identify as the following? 0 being no experience, 5 being a great deal of experience.

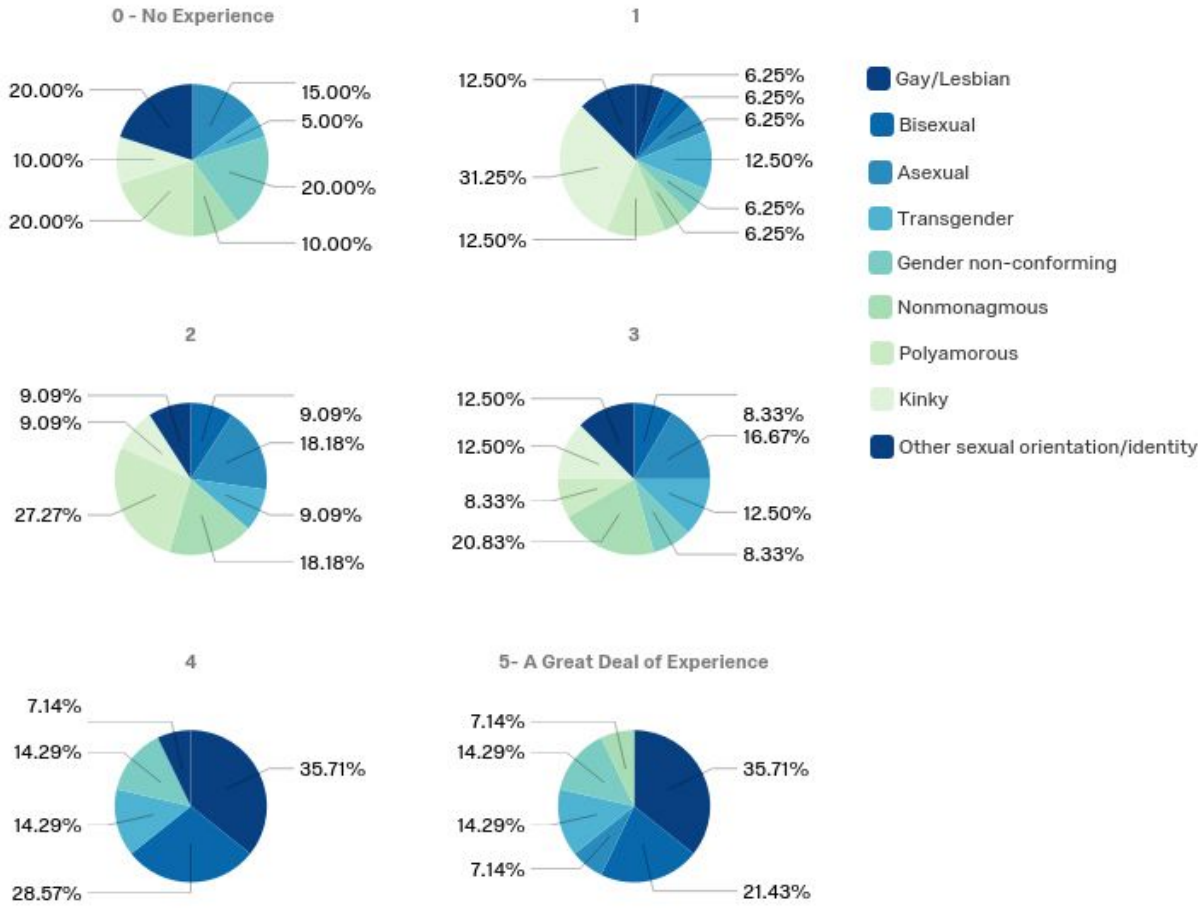

Table 4: Graphs of data from Question #4

The majority of survey participants who reported "0 - no experience" working with certain populations identified that these populations include clients who identify as gender non-conforming, polyamorous, and other sexual orientation/identity. The majority of participants who reported an experience level of "5 - a great deal of experience" with certain populations identified that the populations named in this survey which they have the most experience working are clients who identify as gay and lesbian.

Open Ended Questions.

The survey also asked participants a series of open-ended questions, providing them with the opportunity to report their own thoughts, feelings, and experiences. Of the 11 participants who responded to the first four questions in our survey, 9 responded to the open-ended questions as well. Question #5 (see Table 5) asked participants to describe their experiences with discussions of sexuality in session with clients, including how such topics came up, and what barriers, challenges, and successes they have observed in such discussion. Question #6 (see Table 6) expanded upon this by asking participants to describe their approach to clients who identify as sexual minorities. Question #7 (see Table 7) offered a space for participants to discuss the role of art making in discussions and exploration of sexuality. To protect anonymity and allow comparison between the participants' responses to the different open ended questions, we have identified the participants as "Participant A - Participant I" in the tables presenting the data from these open ended questions:

Question #5: Describe your experiences discussing sex and sexuality in sessions with clients, including how these topics have been brought up, successes, challenges, and barriers.

		Responses
Participants	Participant A	The amount that I talk about sex and sexuality is directly correlated with my knowledge and comfort level with these topics. If I educated myself more and gained more experience, I would probably become more comfortable talking about these subjects with my clients.
	Participant B	I will usually initiate a discussion about sex/sexuality during the assessment session to normalize and encourage this topic and convey my openness talking about/making art about sex when they see fit. I tend to reserve the first sessions for exploring identity broadly, making space for inclusion of sexual identity. Successes: Using a psychoeducation component to LGBT group therapy, group art directives to establish cohesion, viewing art by/for queer artists with clients, using art journal to support the process of coming out, using self-portraits with trans youth to support their transition. Challenges: family therapy when one or both parents are unsupportive, minimal opportunities to process my countertransference in supervision, self- disclosing my sexual identity to clients (can also be a success), encountering clients with violent sexual urges, discussing sexuality with clients who have severe mental illness.
	Participant C	I work mainly with younger children and have had a few teens over the years, so my scope of exposure is limited, however, discussions surrounding these topics are brought up by me during assessment and discussed in a normalized fashion whenever the client or parent brings up a concern. Typically the discussions I have with clients and parents surround normalizing masturbation, teen sexual exploration with partners and client interest in pornography and parenting concerns surrounding these issues. I have been successful in reducing parental discipline of children for these behaviors and curiositys.
	Participant D	Hardly any experience.
	Participant E	Often questions surrounding sex come up during initial assessments. It can be more challenging if there is no rapport established with the client already.
	Participant F	I currently work with adults and the client most typically brings up the topic of sex. However, if there is something that the client is discussing that is related to intimacy or conflict in relationship(s), I will bring it up. I have always had success with both my adult and adolescent clients when they or I bring up the topic of sex and sexuality. Why? It's typically on their mind and they find relief to have someone to talk to that is not judging or pathologizing their thoughts, behaviors, and identity.
	Participant G	Open ended questions on forms asking people to write in their pronouns, gender Asking open ended questions at intake about dating someone not assuming gender. Encouraging clients to talk about their thoughts and feelings about gender and identity. Honestly not focusing on sex as much as identity and communication.
	Participant H	With few exceptions, I try to follow my clients' needs about bringing up sexual experiences and the way they integrate sexuality, gender, and relationships in their lives. However, I make sure I ask about sex and sexuality in our assessment process and when discussing the scope sbd focus of treatment (around consenting to treatment) to signal my interest, ability to dialogue about these topics, and consider clients needs / barriers in addressing these.
	Participant I	Clients have brought them up. It's generally quite "easy" to discuss as I do not push them to divulge if they are not comfortable, and they do not bring it up if they are not comfortable.

Table 5: Data from Question #5

Participants responding to Question #5 shared their experience with discussions of sex and sexuality in therapy sessions with clients, and how these topics come up in sessions. The majority of participants stated that the topic of sexuality is brought up in session with clients during the initial intake.

Question #6: What is your approach to clients who identify as sexual minorities, such as LGBTQIA clients?

		Responses
Participants	Participant A	I may do my clients a disservice by not making the space comfortable for sexual minorities.
	Participant B	As a queer therapist I approach my work with LGBTQIA populations passionately and with the belief that the client is the expert of their identity/experiences.
	Participant C	I typically include questions of orientation in the assessment and look for opportunities to seek clarification of the client's perspective throughout treatment. I also keep empowering visual images (such as the = sign) visible in my office to cue clients that I am open and receptive to any discussion they may want to have.
	Participant D	Being open and not making assumptions. I identify within the LGBTQ community which is something I take with me into my approach but I still recognize everyone's experience is different and unique to them.
	Participant E	I treat clients as equals and I only address LGBTQIA identities if they state that they're experiencing problems relating to that identity.
	Participant F	Remain open, non judgmental, non pathologizing. Never assume one's SOGIE. Understand the fluidity of identity and the possibility of trauma including rejection related to identifying as LGBTQ+.
	Participant G	Open accepting supportive nonjudgmental
	Participant H	I attempt to approach all my clients' experiences (and my own) with sexuality through respect, curiosity, and openness to how relational experiences, somatic / symbolic terms, and the specific contexts of their lives make meanings.
	Participant I	My approach is open and curious and willing to learn what I do not already know.

Table 6: Data from Question #6

The majority of survey participants responding to Question #6 described their approach to working with clients who identify as sexual minorities with words such as "open" and "nonjudgmental". Some participants also specified things that they take care *not* to do, such as "making assumptions".

Question #7: Describe the role art making has played in your clients' explorations of sex and sexuality in sessions.

		Responses
Participants	Participant A	Sexual trauma and sexuality has been elicited through the art process without intention.
	Participant B	A significant role, a few that stand out: Art-making with queer youth/identity formation. Mask making and self portraits with trans clients. With couples, art has facilitated corrective emotional experiences following sexual transgressions/boundary violations, offered a form of nonviolent communication to partners struggling with IPV. With some clients, art has helped with the internal transformation from victim to survivor. Art has also provided a means to empower clients with knowledge of sexual integrity/boundaries.
	Participant C	My clients typically enter treatment due to childhood trauma and issues of sexuality are often intertwined with their narratives, so the act of artmaking helps the children I work with to separate and combine the layers to open up and examine the experiences.
	Participant D	N/a
	Participant E	I've had clients identify sex and masturbation (in an art therapy intervention) as preferred positive coping strategies.
	Participant F	Most of my clients have not used art to explore sex or sexuality. Occasionally, some will use collage to communicate their feelings and thoughts.
	Participant G	Asking clients to draw thoughts and feelings about identity.
	Participant H	Art making is the most impactful way I know to offer both containment/ safety and open / bold expression of a difficult topic for many to articulate. Art also invites the client ti enter a dialogue within his/ her/ themselves and offers the therapist a joining stance, literally looking at the experience (joy / pain/ wish/ challenge) with the client, from a similar perspective, yet slightly removed from where the client is sitting.
	Participant I	Not much experience here.

Table 7: Data from Question #7

Multiple survey participants responding to Question #7 reported utilizing art to facilitate discussion about identity relating to identity. Another common response amongst survey participants was the unintentional result of content regarding sexuality emerging from art-making in sessions when this content was not specifically elicited. Participants who had little or no experience using art to discuss these topics stated this here.

Questions #8 - 10 (see Tables 8 - 10) were designed to obtain further information about the participants' backgrounds and experience relating to this topic, including training received,

cultural affiliations, and interest or motivation in taking the survey. Question #11 (see Table 11) invited participants to identify sexuality-related topics which they believe would be helpful for them to continue learning more about. Question #12 (see Figures 1 - 2) was marked "Optional" as a consideration for participants' time and technological abilities, but invited them to create a piece of art showing what discussing topics related to sexuality in sessions with clients is like for them. The survey included the ability for participants to upload an image of their artwork and submit it along with their responses to the previous questions.

Question #8: What Training have you received related to topics of sex and sexuality?

		Responses
Participants	Participant A	I received one class at LMU.
	Participant B	I think my graduate research influenced my clinical competency with LGBTQ clients more so than any training or workshop I've been to. I've sought out additional opportunities to learn by attending a CSEC trainings, DMH trauma trainings for survivors, Models of Pride, and the EDGY conference.
	Participant C	I have received training on LGBTQIA concerns, sexual trauma, and positive attitudes about sex.
	Participant D	None, but I am interested in it.
	Participant E	Little to none since graduate school. I attended an LGBTQ "Safe and Supported" Training recently which was optional at my agency.
	Participant F	Internship, participation in trainings and workshops, I train and teach on the subject which keeps me updated.
	Participant G	LGBTQ allied training Trans allied training Transgender ceu training
	Participant H	I'm a registered sex therapist (as well as MFT and art therspist). I attendAASECT conferences, EFT trainings, read books and worked with clients specifically needing to address sexual concerns (initially under supervision abd still at times - with additional consultations).
	Participant I	Only training specific to sex and sexuality was in grad school, though through sensorimotor training this has been indirectly addressed (in terms of touch, etc).

Table 8: Data from Question #8

Participants responding to Question #8 named the amount of training they have received regarding these topics. The majority of survey participants reported receiving trainings both in school and outside of school on the topics of sex and sexuality.

Question #9: If you feel any cultural affiliations might help us contextualize your experiences (e.g. your age, gender, ethnicity, sexual orientation, etc.), please include those here.

		Responses
Participants	Participant A	My family was not comfortable talking about sex and sexuality which has influenced my discomfort.
	Participant B	Mid-twenties, White, cis-gender, bisexual femme-presenting female in an interracial monogamous relationship with a cis-gender female partner.
	Participant C	I identify as a 27 year-old heterosexual, Caucasian, female.
	Participant D	Female, bisexual in a commited relationship with a woman, 26.
	Participant E	I'm 31/female/pansexual.
	Participant F	53 year old, identify as cisgender gay male. White identity.
	Participant G	I am a cis gender straight white 42 year old woman gender conforming.
	Participant H	42 year old middle eastern cis gendered woman, spiritual but not religious, survivor of family sexual trauma, military veteran, mother, widow/ currently single, working with couples and adoption / foster care related issues in private practice.
	Participant I	Mid-30s, female, Pacific Islander, straight, but with family members who have identified as gay and lesbian.

Table 9: Data from Question #9

Participants responding to Question #9 reported cultural affiliations ranging from sexual identity and gender identity to racial and ethnic identities. Participants chose to report different types of cultural affiliations and identities, including some who shared their relationship status or family background.

Question #10: What was your interest or motivation in taking this survey?

		Responses
Participants	Participant A	I wanted to help out the LMU community of researchers.
	Participant B	I felt compelled to contribute because this is such important research and I feel a sense of pride supporting any work which affirms sexuality.
	Participant C	I like to support research in the field of art therapy.
	Participant D	To help fellow LMU students!
	Participant E	LMU Alumni
	Participant F	Helping LMU students in their academic growth and milestone.
	Participant G	I Support students both by doing their survey and is providing therapy to college students.
	Participant H	I think this topic and intentional contribution is a much needed gap in our current art therapy theory and practices.
	Participant I	To help! Good luck!

Table 10: Data from Question #10

Participants responding to Question #10 shared their interest or motivation in participating in this research. The majority of participants named that helping LMU students with their research was their motivation or interest, and some expressed their enthusiasm through the use of punctuation such as exclamation marks.

Question #11: What topics do you think would be helpful for you to learn more about? (select as many as apply)

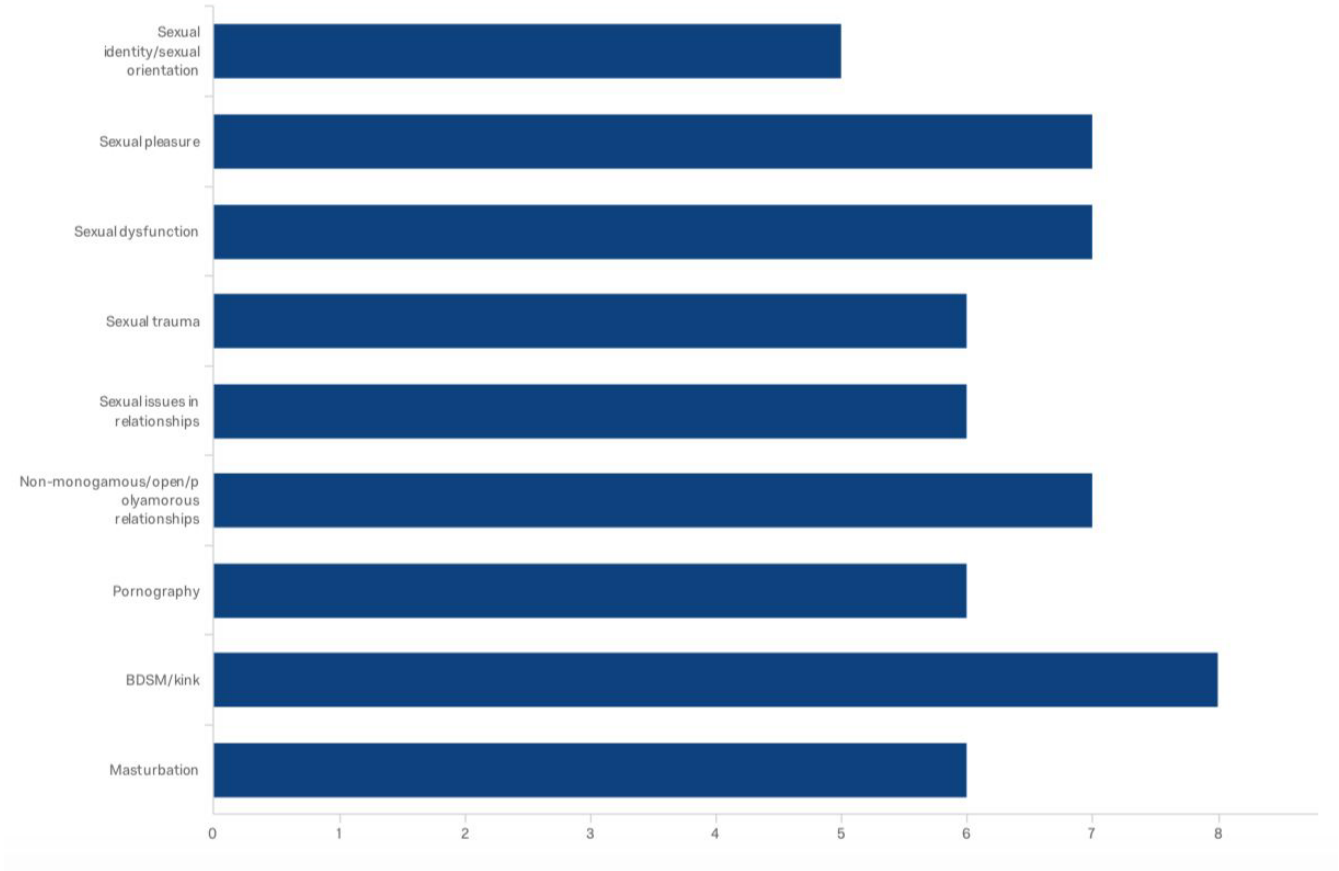

Table 11: Graph of data from Question #11

Table 11 shows that survey participants identified an interest in learning more about most of the topics listed here. BDSM/kink was the topic that the most participants named as one that would be helpful to them to learn more about.

Art Responses.

Question #12 consisted of an optional art response piece. The directive given to participants was "Create a piece of art that shows what discussing topics of sex, sexual identity, and sexuality in session with clients is like for you". Participants were asked to upload an image of their artwork to Qualtrics to respond to this question. Two of the survey participants chose to create art responses, shown below in Figures 1 and 2:

Figure 1: Artwork created by Participant H in response to the directive

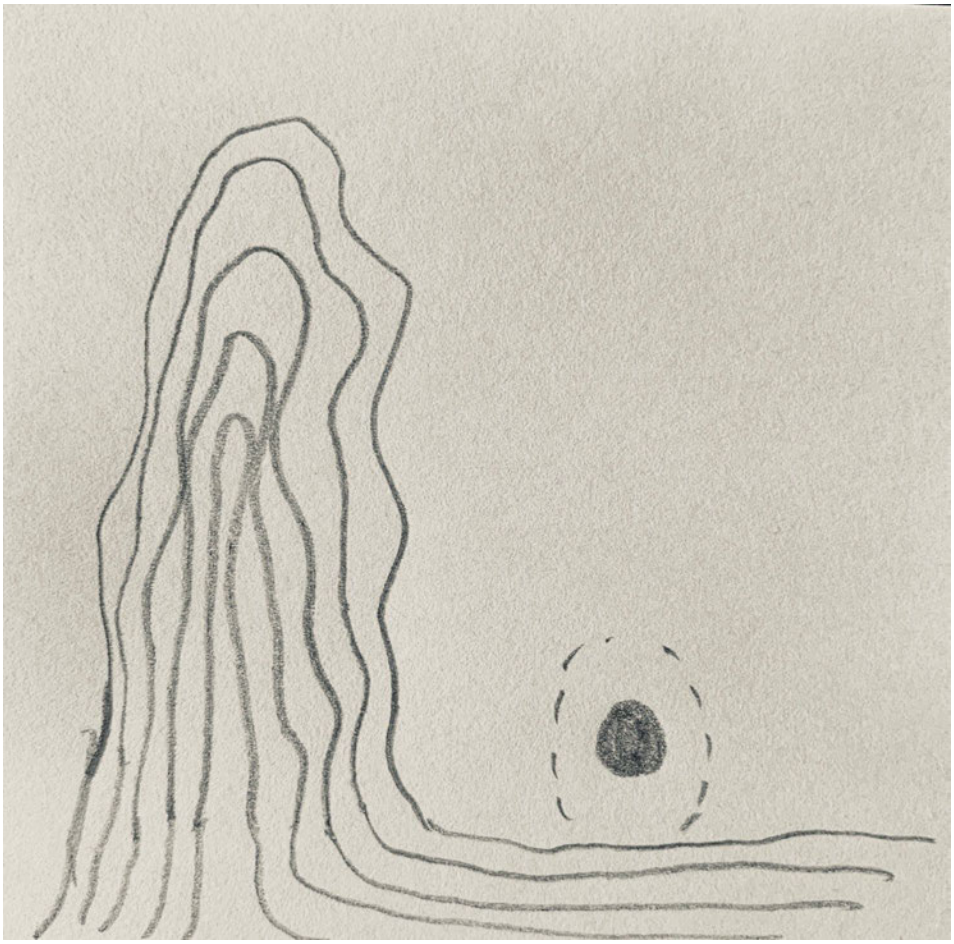

Figure 2: Artwork created by Participant I in response to the directive

Interview.

We originally planned to conduct a focus group consisting of participants recruited from the pool of participants who completed our survey. Survey question #13 asked participants to provide their contact information if they would be interested in joining such a focus group. Of the 11 participants who responded to the survey, two expressed interest in the focus group. Unfortunately, due to scheduling and availability, only one of these two participants was able to attend the dates offered for the focus group. Thus, we decided to conduct an interview with the individual participant, rather than a focus group.

We chose a semi-structured format for the interview, as this allowed us to prepare a set of questions based on our research questions, but also left room for flexibility and openness to new ideas or questions that could come up during the interview based on the information shared by the participant. The interview was conducted via Skype video chat, in a three-way chat format between the interview participant and the two researchers. The participant was invited to attend an in-person interview, but due to scheduling and distance she requested to be interviewed remotely instead. The participant was emailed the Subject's Bill of Rights and signed a consent form prior to the interview, which included consent to audio-record the interview. The interview lasted approximately 60 minutes.

The interview consisted of 12 planned questions (see Appendix G), with Question #12 being an optional art response. Questions # 1 - 4 focused on the participant's clinical experience, specifically inquiring about education, experience, and comfort level discussing sex and sexuality in sessions with clients. Question #5 asked if there were any populations which the participant would not be willing to work with or would not feel qualified to work with, or if there are any topics the participant would not feel comfortable discussing with clients, and why. Questions #6 - 9 focused on the the participant's experience discussing these topics in therapy, including challenges and barriers, and how art-making in therapy is used in relation to these topics. Question #10 asked the participant about their own cultural beliefs, biases and experiences and how these have influenced their views of sex and sexuality. Question #11 provided an opportunity for the participant to share how they think art therapists could improve their knowledge or skills regarding discussion of these topics with clients in sessions. And finally, Question #12 was an optional art response that invited the participant to create a piece of

art about how art therapy helps facilitate discussions of sex and sexuality in therapy. As the interview did not follow a linear path, interview responses are organized below, grouped by theme with relevance to interview questions:

The Participant.

The interview participant is a practicing art therapist who received her master's degree from Loyola Marymount University. She identifies as queer, and reported that because she became known as "the queer therapist" in her community, many of her clients in private practice have also identified as queer, polyamorous, and/or transgender. She focuses on working with couples, and is bilingual in both English and Spanish. She stated that she previously practiced art therapy in a very liberal city, but currently practices in a more conservative region.

Experience.

When we asked the participant what kind of experience she has had discussing sex and sexuality with clients, she readily replied "a lot!" and stated that these subjects come up with "every one of my clients." She went on to explain that she is often the one to initiate such conversations in therapy: "I think that, when it comes to sexuality, it's obviously something personally I've been very used to having to have that conversation, and so then I bring it up pretty early on in my intake process." She reported that she is "very, very comfortable" talking about these subjects with clients, which she cites as a result of her own sexual identity, as she stated: "I'm also queer so I feel very comfortable asking or bringing [sex and sexuality] up pretty immediately." She speculated that because of her willingness to talk about these topics with clients, her coworkers and colleagues often ask "Why is it that you always get all the gay clients?" But the participant attributes this to the fact that she asks her clients about their

sexuality, whereas she theorizes that these other therapists "never asked," so their clients never disclosed.

When asked if she felt that the courses she took for her master's degree helped to prepare her for discussing these topics with clients, the participant was quick to frown and reply "no!" before the interviewer even finished asking the question. She stated that she educated herself on the topics of sex and sexuality through resources such as books, which she often recommends to her clients: "I love Esther Perel, *Mating in Captivity*, and *Ethical Slut* ... I think because I've read them all, I very comfortably would like include them in my practice." She also went on to cite "TED Talks and podcasts" as additional resources she has used to further educate herself on these topics. The participant reported that although she is not trained or certified as a sex therapist, she has also had experience teaching human sexuality courses, which has contributed to her knowledge of this subject and her ability to educate clients on these topics. She explained how helpful she has found it to talk about subjects such as consent and sexually transmitted infections with clients, and emphasized again: "I really enjoy it, you know. I think because I genuinely don't get uncomfortable with the topic, and so, they feel that probably, and then they're like 'okay cool'."

She also expressed humility and awareness of room for continued growth and learning, particularly regarding learning new terminology, and stated "I'm learning something every day." The participant identified her own biases and beliefs, noting that although her family was supportive and accepting of her when she came out, she recognizes that her clients may have very different experiences. Particularly regarding the topic of coming out, she linked her own experiences with being queer in the larger heteronormative world, beyond her supportive family,

to the empathy she has for her clients: “I feel like that really keeps me very connected to my clinical practice, and realizing why people won’t, you know, speak up… I’ve never once I think felt judgment towards someone who doesn’t want to come out.”

Challenges and Barriers.

On the subject of challenges and barriers that may prevent or discourage clients from opening up and discussing these topics in therapy, the participant stated: “I would say if they’re in part of a community where they *have* to disclose if they want to be seen, and validated, you know, as that, then they’re a lot more comfortable bringing it up. I think if they’ve lived a life with privilege, whether it’s sex or sexuality, gender, whatever it is, then they tend to be more, kind of shy around the topic and won’t bring it up unless I’m asking directly or bringing it up directly.” But she went on to emphasize that safety is a key concern for many clients who identify as sexual minorities, noting that if clients do not perceive their therapist as “supportive,” then they may feel unsafe discussing these topics.

She also noted that cultural norms can present barriers to discussion of these topics, and pointed to shame as a reason why clients who identify as sexual minorities may have trouble talking about their sexuality, as “all systems around them were pretty much saying “don’t talk about it, or hide’.” And she also observed that cultural values and shame can contribute to heterosexual clients’ comfort discussing these topics in therapy as well. As an example of this, she described some Latina clients who she noted were not comfortable discussing masturbation because they were taught that it was a sin: “It wasn’t that they didn’t masturbate, but it was hidden, you know?” The participant disclosed that she herself received such messages about mastrubation as a child as well, although she laughed when describing those beliefs now. She

also disclosed a negative experience she had in her own personal therapy, discussing a therapist who she described as "*obsessed* with my gayness." The participant reported that this therapist kept focusing on the participant's sexual orientation, even when the participant wanted to focus on other topics in therapy. She stated that this came to a point where she felt the need to confront her therapist and ask her "Are you gay? Like, are you projecting? ....What's going on?"

Regarding challenges that therapists face when it comes to being comfortable discussing these topics with clients, the participant speculated that it is difficult to ask therapists to be comfortable talking about these subjects when our society as a whole is still uncomfortable with them. She stated: "I think we have a long ways to go for it to just be integrated into even a master's program… It's like the world has to change for therapists to get there too." She was also critical of the textbooks used in art therapy and marital and family therapy master's programs, exclaiming: "Every fucking book we read is so hetero, like everything!" And she expressed frustration with the even greater lack of sexuality courses in other schools where she has taught, describing the faculty at one school as "completely outdated" in their response to issues regarding sexuality.

Even for licensed clinicians, the participant expressed that she does not believe there are enough requirements for training on these topics. She stated that such training "should be just one of the mandatory parts of getting your license every two years again, it should be like law and ethics." But ultimately, she emphasized that becoming comfortable with discussing these topics can only be learned through experience: "If they've never exposed themselves and if they don't feel comfortable having those conversations then, I mean they just need to go and have them, but that's easier said than done, right?"

When asked if there were any types of clients she would not be willing to work with or would not feel qualified to work with, or any topics she would not feel comfortable discussing, the participant pondered the question and considered different experiences with clients she has has in the past, but concluded "my answer is no". She reported that she has worked with sex offenders in the past, and stated that although she acknowledges that "it's hard," she would work with such clients again in the future. However, later in the interview she came back to this question and reported that she remembered a client who she had turned down in the past: "It was parents who wanted me to do conversion therapy with their son." She stated that she was not sure she would turn such a client away now, as "Now, I would be like, well they got him here, and so it's an opportunity…" but amended this thought with the consideration "I don't know if that would be ethical, because I would have to agree to something [conversion therapy] that I'm really not going to do."

Art Therapy.

Discussing art therapy specifically, the participant reported that she has found it "absolutely" helpful to clients exploring sex and sexuality in therapy: "I think it allows for a very non-threatening way for them to, you know, look at and analyze and be curious about together." She noted that some of her clients enjoy using loose, fluid materials such as watercolors to explore their sexuality through art-making: "It allowed for this creation of very, like Georgia O'Keeffe-style... very, you know, flowerly, vagina/vulva-looking." Although, in contrast, she reported that when working with couples, she found that "They always stick with very non-threatening materials, like markers." The participant stated that she does not have one specific intervention she relies on, but has used some with similar themes, such as

"internal-external" directives, as well as bridges or journeys, which can be used to show where the client wants to get to, and what barriers stand in their way.

The participant emphasized that discussion of the artwork is an important part of the process, stating: "I would say it really, really helps them have a way to talk about it, just by explaining what's visually in front of them, vs. what they actually experience - which is the same thing, but, you know." She also described a visual exercise she uses with couples, in which she asks them to use their hands to demonstrate what it is like when they have sex together: "Kind of touch hands, and then show me what that dynamic would be. If one person's the initiator, or whatever, and then they would initiate... What does that look like?"

Art Response.

The participant had been asked ahead of time to have some art supplies of her choosing ready if she would like to create an art response as part of her interview. After we had asked her all of the previous questions, we invited her to create a piece of art showing how art therapy can create a space in which clients can open up about sex, sexual identity, and sexuality. The participant appeared excited to make art, and began working quickly, spending just over four minutes drawing before announcing that she was finished and holding up the artwork for us to see through the webcam. She noted "I could keep going, but, I'm going to stop myself."

The artwork she created (see Figure 3) was drawn with various colors of markers on a vertical white piece of paper. Due to the angle of the webcam, we could not see the piece while she was working on it, but saw the finished product when she held it up for us to view. She had drawn a black line horizontally across the paper, about two thirds of the way down the page. Above this baseline, in the middle of the page, was a door, also drawn in black marker. Colorful

line, spirals, and shapes emerged from the edges of the door, radiating outward towards the edges of the paper. On the door itself was drawn a round door knob, and smaller lines of colored markers were drawn around this doorknob, radiating outward from it in a smaller version echoing the lines radiating out from the door frame itself.

Describing what she had drawn, the participant said: “So, it’s pretty much this door, and if you dare to open it, it’s a beautiful, chaotic mess. Exquisite. But then you get a little idea, but the idea is, the door is closed, so you do have to very intentionally open it.” She explained that this intentional opening of the door is a joint effort of both client and therapist, and that both are needed to help open the door. The participant continued reflecting on her artwork, and commented: “It’s just more of this very contained structure, door, and there’s this tiny bit of sign that, you know, there’s like a lot more. But I feel it depends on which side of, it’s almost like there’s this side, you know -” She held up her drawing again. “This could be the therapy too,” she said, gesturing to the blank space at the bottom of the page. “It’s just clean, you know? Or you can walk here,” she continued, pointing to the door in the center of the drawing. “It’s almost like there’s a choice.” She again emphasized the importance of discussing artwork about sexuality with clients, “because you could actually explore all of this visually and non-verbally and then never talk about it.”

Figure 3: Artwork created by the interview participant

Analysis of Data

After we collected and organized our data, we analyzed it looking through the lens of our research questions:

1. How do art therapists use art therapy techniques, materials, and directives to create a therapeutic environment in which clients can open up about their sexuality?
2. How comfortable and/or experienced are therapists regarding discussion of topics related to sex and sexuality with clients in therapy sessions?
3. What barriers are there to discussing sexuality in therapy, and how does art help overcome those barriers?

Within the data collected through our survey, we compared and contrasted answers from our survey participants, identifying key ideas and themes. As we were only able to conduct one interview, we were not able to do a similar comparison between different interview participants, but we were able to compare the themes that emerged from interview with the themes from the survey data.

The survey data was analyzed through Qualtrics software. There, we explored different visual representations of data (e.g. bar graphs, line graphs, tables, pie charts) and color options for these graphs. We also created spreadsheets to display the responses to open-ended questions, identifying survey participants by letters ("Participant A" through "Participant I") in order to protect their anonymity but show which responses came from the same participant. We chose to introduce the data in the order that the survey questions were given, and created graphics from the Qualtrics graphs and spreadsheets to present the data. When presenting the artwork, we discussed how best to describe the process and the content of each image. Since we had not

asked the online survey participants to include a statement or a description of the artwork submitted, we decided to only describe the formal elements of the artwork, as making interpretations or assumptions about the artwork or describing what we perceive would be untrue or false, possibly contributing to misleading data. Describing the formal elements sufficed in many ways for this research, specifically for comparison to the formal elements of the interview participant's artwork. However, we feel it would have been beneficial if we had included an additional field in which the survey participants could have described their artwork or included a statement about it.

To organize the data from our interview, we first transcribed the entire audio recording. As the interview was conducted in a semi-structured format, although it followed a list of questions, the interview participant's responses and subsequent dialogue with us, the researchers, often touched on many of the themes of our research. So in presenting the data from the interview, we organized the interview participant's responses by theme, rather than by question, and presented select quotations and summary of the conversation. The interview participant created her art response during the interview, and described both the process and content to us after she created it, so we were able to include her own explanation of it as well as our description of the formal elements of the art in our analysis of the data.

1. How do art therapists use art therapy techniques, materials, and directives to create a therapeutic environment in which clients can open up about their sexuality?

In our Qualtrics survey responses, Question #7 addressed the role of art making in client exploration of sex and sexuality in sessions. Three of our participants reported no experience or use of art making to facilitate the conversation about sex and sexuality. Interestingly, one

participant, Participant A, stated that “Sexual trauma and sexuality has been elicited through the art process without intention.” Similarly, Participant C stated “My clients typically enter treatment due to childhood trauma and issues of sexuality are often intertwined with their narratives, so the act of artmaking helps the children I work with to separate and combine the layers to open up and examine the experiences.” Two participants named that art-making has helped facilitate exploration of feelings around identity, and Participant B named specific directives used to explore identity when working with clients who identify as transgender. And another participant reported that the topics of sex and masturbation were brought up in an art intervention as preferred, positive coping strategies. One outlier in our responses was a participant who named that the artwork provides a sense of safety and containment as well as the ability to further treatment, as the therapist is able to visually see where the client is at and witness/join in their experience, something that none of the other survey participants mentioned.

The participants who uploaded art responses to the Qualtrics survey each used different art materials: one, a photograph; the other, what appears to be pencil on paper. Although done in very different mediums, the artwork appears to share some common imagery and themes. We observed an asymmetrical quality to the composition of both images, with one side of the piece being taller than, or towering over, the other. Another common element to the artwork is a stark contrast between a lighter background and the primary subjects or figures in the art piece. Additionally, there are definitive lines in both pieces: the pencil has bold, thick lines with no visible erasure marks on the page while the photograph’s shadows show distinct, definitive shapes against the background.

Analyzing the data from the interview, we noticed that the interview participant named ways of utilizing art therapy techniques to facilitate discussion of sex and sexuality in sessions with clients that were similar to those named by some of the survey participants. The interview participant identified the use of art as a way for clients to explore aspects of sex and sexuality. While the survey participants did not name specific materials utilized by clients in their process of exploring these topics, the interview participant reported using looser materials with clients exploring sexuality, although she also pointed out that more structured materials like markers are generally preferred by couples. Additionally, the interview participant named specific directives she has given to couples.

Looking at the artwork created by both the survey participants and the interview participant, we found some similarities: The line quality from the interview participant's artwork is similar, as it is bold in line quality with some shapes that could be considered abstract or organic. Similar to the photograph submitted by one of the survey participants, the interview participant's artwork has a stark contrast and definitive objects that stand out in the piece. The pencil drawing submitted by the other survey participant also shows strong line quality and bold shapes, and their drawing was completed in solid lines with no shading except for the small circle on the left side of the page which was filled in.

2. How comfortable and/or experienced are therapists regarding discussion of topics related to sex and sexuality with clients in therapy sessions?

Analyzing and comparing the data from the likert scale questions used in the survey, we found that the majority of the participants reported that they were comfortable discussing sex and sexuality with clients, but were more comfortable with discussion of some specific topics than

others. Survey Questions #1 and #3 were likert scale questions addressing therapist comfort level. Specifically, survey Question #1 asked participants to identify their overall comfort level with discussions of sex and sexuality in sessions with clients, on a scale of 0 to 5, with 0 being "uncomfortable" and 5 being "very comfortable". The majority of participants marked "4" on this scale.

However, when looking at Survey Question #3 which broke down comfort level by topic, it became clear that even though only one participant had rated their overall comfort level as a "2" (Survey Question #1), when given the opportunity to specify different comfort levels for different topics, multiple participants indicated lower ratings on the same 0 to 5 scale. The majority of participants marked "5 - very comfortable" when working with clients discussing sexual identity or sexual orientation, sexual trauma, and sexual issues in relationships. The majority of participants answered equally "4" or "5" when discussing with the topics of sexual pleasure and masturbation. And the majority of participants answered "4" regarding discussing sexual dysfunction and non-monogamy/polyamory/open relationships with clients. But when it came to discussing the topic of pornography or the topic of BDSM/kink with clients, the majority of participants identified their comfort level as a "3".

Survey Questions #2 and #4 were also likert scale questions asking participants to identify their level of experience working with different aspect of client sexuality. These questions also utilized a scale of 0 to 5, with 0 being "not at all", or "no experience", and 5 being "very experienced/expert" or "a great deal of experience". Survey Question #2 asked participants to identify their levels of experience talking about specific topics related to sex and sexuality in sessions with clients. The majority of participants marked "4" when it came to their experience

talking about sexual identity/orientation and sexual issues in relationships. Regarding discussions of sexual pleasure, sexual dysfunction, sexual trauma, and pornography use, the majority of participants marked a "3" on the scale. Additionally, equal amounts of participants answered "0" and "4" to identify their experience level talking about non-monogamy with clients.

Survey Question #4 asked participants to report their level of experience working with different sexual identities, and allowed participants to rate their level of experience working with clients who identify as the following: gay and lesbian, bisexual, asexual, transgender, gender nonconforming, non-monogamous, polyamorous, kinky, or other sexual orientation/identity. Participants were asked to indicate their level of experience on a scale of 0 to 5, with 0 being "no experience" and 5 being "a great deal of experience". The majority of participants answered "3" to indicate their experience working with clients who identify as asexual, transgender, or non-monogamous. The majority answered "0" regarding their experience working with clients who are gender nonconforming, polyamorous, or clients who identity as "other sexual orientation/identity". The majority of participants reported that their level of experience working with gay and lesbian clients was "4" or "5," and the majority reported that their level of experience working with bisexual clients is "4". When it came to clients who identify as "kinky," the majority of participants rated their experience level as "1." This section of the research shows that therapists' reported comfort level working with a variety of sexuality preferences and identifiers, as well as different topics, is higher than the therapists' actual experience level working with that clientele.

Although eleven participants responded to the first four survey questions, only nine responded to the open-ended questions. It is possible that this is attributable to the amount of

time it would have taken to write out responses to the open-ended questions, and the two participants who did not continue taking the survey beyond the likert scale questions may have been willing to answer short questions, but may not have been able to take the time to write longer responses. It is also possible that while it was easy for participants to select a number on a likert scale to report their comfort level and experience regarding discussions of sex and sexuality, they may have felt less comfortable describing the details of their own experiences as therapists.

Analysis of the data collected from these open-ended questions revealed both commonalities and differences between the different participants. Survey Question #5 asked participants to describe their experiences discussing sex and sexuality in sessions with clients. Several participants reported that they initiate conversations with clients about these topics, which could indicate a certain comfort level with such discussion. And five of the nine participants noted specifically that these topics are brought up in early assessments or through intake forms. The outlier was Participant A, who was the only participant to also explicitly mention their comfort level in their response to this question. Participant A reported: “The amount that I talk about sex and sexuality is directly correlated with my knowledge and comfort level with these topics. If I educated myself more and gained more experience, I would probably become more comfortable talking about these subjects with my clients.”

Survey Question #6 asked participants “What is your approach to clients who identify as sexual minorities such as LGBTQIA?” A common theme that emerged from analysis of this data was the use of the word “open” or “openness” by six of the nine participants in describing their approach to working with such clients. This appears to indicate a comfort level with being open

to hearing clients discuss their sexuality and identities. The outlier again was Participant A, who, having previously identified their own discomfort with discussing sex and sexualtity, now reported: “I may do my clients a disservice by not making the space comfortable for sexual minorities.” Although the participant did not specify what they believe makes the space less comfortable for their clients, or what they believe they could do to make it more comfortable, their acknowledgment in their previous answer that greater education and experience would improve their comfort level may likely apply to the space they create for their LGBTQIA clients as well.

Looking at the responses to survey Question #9, which invited participants to name any cultural affiliations which they thought might help us contextualize their experiences, we noted that five of the participants identified as members of the LGBTQIA community. It is likely that their comfort working with sexual minorities may be attributable to this. Participant A did not disclose any information about their age, gender, sexuality, race or ethnicity, but reported: “My family was not comfortable talking about sex and sexuality which has influenced my discomfort,” naming the cultural background which has impacted their approach to discussing these topics with clients.

The artwork created by the interview participant demonstrates her comfort level with discussions of sex and sexuality with clients, as evidenced by her description of the content of her art: She indicated that the door she drew represents a barrier that must be opened to facilitate discussion of these topics, and described what lies behind the door as “beautiful” and “exquisite”. Her choice of these words appears to show both her comfort with and passion for discussion of these topics with clients. As the participant created her art response while engaged

in a video chat with us, the researchers, we were able to witness her engaging in the art-making process. Although the angle of the camera prevented us from observing the artwork itself while she worked on it, we were able to see that she began drawing right away, and appeared confident and sure of what she was drawing. These behaviors may further demonstrate her comfort level not just with discussing these topics with clients, but also with reflecting on her own experience of those discussions, and sharing her experience with others.

Analysis of the rest of the interview revealed that the participant appears to possess a high level of comfort with discussion of sex and sexuality in sessions with clients, as well as an enjoyment of such conversations. The participant cited her own sexual orientation as a factor in her comfort level, stating: "I'm also queer so I feel very comfortable asking or bringing [sex and sexuality] up pretty immediately." She also reported that she has become very knowledgeable on these subjects in part because she has taught human sexuality courses in the past.

Throughout the course of the interview, the participant named multiple populations and sexual identities with which she has worked and is comfortable working with: single clients; married couples; clients in polyamorous relationships; heterosexual clients; and clients who are members of the LGBTQIA community, including specifically clients who identify as gay or transgender. When asked if there are any clients she would not feel willing, qualified, or comfortable working with, the participant stated that she could not think of any. She reported that she has worked with sex offenders in the past, and while she described it as "hard," she stated that she would still consider working with such clients again in the future.

3. What barriers are there to discussing sexuality in therapy, and how does art help overcome those barriers?

Although none of the likert questions in our survey explicitly asked participants about barriers to discussing sexuality in therapy, the data we collected regarding therapist comfort level and experience level itself revealed themes that are relevant to identifying and exploring these barriers. Survey Question #1 asked participants what their overall comfort level is when discussing sex and sexuality in session with clients. Although the majority of participants reported their comfort level as a "4" regarding such discussion, one participant reported their comfort level as a "2" when it comes to these topics, suggesting that this lower comfort level could be a barrier.

The data collected by survey Question #3 expanded upon this exploration of comfort level, identifying that even therapists who reported that they feel comfortable with these topics overall still reported levels of discomfort when it came to certain topics within the broad category of sex and sexuality, such as BDSM/kink, non-monogamy, or pornography. Similarly, survey Question #2 asked participants about their experience level with these specific topics. Since the data we collected from these questions revealed that there are certain topics and certain sexual identities which the majority of therapists surveyed reported a lack of experience with, it is possible that this presents another barrier to discussion of these topics in therapy. However, analysis of the data from both survey Question #2 and survey Question #3 revealed that while the number of participants reporting a lack of experience with certain topics was similar to the number of participants reporting discomfort with these same topics, other topics that participants reported a lack of experience in did not seem to arouse the same discomfort in participants.

The majority of participants rated their experience level as a "2" (on a scale of 0 to 5 with 0 being "not at all" and 5 being "very experienced/expert") when it came to the topic of

BDSM/kink. Similarly, the majority of the participants placed their comfort level with this topic between “1” and “3”. Thus, it is possible that some therapist discomfort regarding this topic may stem from a lack of experience. But while four participants rated their experience level on the low end of the likert scale when it came to sexual issues in relationships, the majority indicated that they feel comfortable discussing this topic with clients. Similarly, while the majority of participants reported low experience regarding discussion of masturbation, the majority also reported feeling a high level of comfort when it comes to talking about this with clients.

It appears that there are some topics which therapists are less experienced talking about with clients, but nonetheless would be or believe they would be comfortable talking about. It is possible that some of these therapists have had personal experience with these topics, or have talked about them with others outside of the context of therapy sessions, and therefore feel familiar and comfortable with such discussion. It also may be that therapists have received education and training on these topics and how to discuss them with clients in a clinical setting, increasing their comfort level with these topics even though they have only had little or no experience actually discussing these topics in sessions. If that is the case, the therapist’s lack of experience may not necessarily pose a barrier to such discussion, as long as the therapist feels comfortable and knowledgeable discussing the topic.

Analysis of the data collected from survey Question #4, which asked therapists about their experience level with different populations and identities, also indicates that therapists have limited experience with certain populations. This could be a barrier to treatment and discussion of sex and sexuality with clients, if clients are reluctant to disclose or talk about their sexual identity to a therapist who presents as less experienced working with clients of that identity. The

data revealed that the majority of therapists reported a lack of experience working with clients who identify as gender non-conforming, non-monogamous, polyamorous, or kinky. Because these identities already carry social stigma and are often misunderstood by others, such clients may be hesitant to discuss this aspect of their sexuality and identity with a therapist who is inexperienced in working with that identity.

Looking at the data collected from the open-ended questions in our survey revealed an even greater depth of information: Survey Question #5 asked participants to describe their experiences discussing sex and sexuality in session with clients, including how these topics have been brought up, successes, challenges, and barriers. One participant self-identified that their own discomfort with topics of sex and sexuality creates a barrier to discussing these topics in sessions with clients: "The amount that I talk about sex and sexuality is directly correlated with my knowledge and comfort level with these topics. If I educated myself more and gained more experience, I would probably become more comfortable talking about these subjects with my clients."

Analysis of the other responses to this question revealed that even survey participants who described themselves as comfortable discussing these subjects still observed challenges and barriers to such discussion in their own practice: One therapist pointed out that when this discussion comes up during intake, "It can be more challenging if there is no rapport established with the client already." Two therapists who reported that they work with children and adolescents noted that a client's parents can pose a challenge to this discussion. And one noted that "family therapy when one or both parents are unsupportive" is particularly challenging,

while the other participant described what they view as a need to "normalize masturbation and teen sexual exploration" for both the client and parents in such family therapy situations.

Several participants also cited ways in which they proactively work to overcome barriers to discussion of sex and sexuality in sessions: Five therapists reported that they usually bring up these topics, especially during intakes and initial assessments. Multiple participants emphasized the importance of initiating this discussion, with one therapist reporting that they do so to "normalize and encourage this topic," and another stating that they bring it up "to signal my interest." Another therapist talked about using open-ended questions on intake forms and in discussion with clients when asking them about gender, pronouns, or relationships.

Survey Question #6 asked participants what their approach is to clients who identify as sexual minorities such as LGBTQIA. The majority of the responses to this question included words such as "nonjudgmental" and "open" or "openness," indicating that therapists are likely aware that clients who identify as sexual minorities may have faced a great deal of judgment from other people in society and their own personal lives, which could impact their willingness and ability to be open about and to discuss their identity in therapy. One participant reported that they place "empowering visual images (such as the = sign)" in their office to "cue" clients that they are open to discussion of sexual minority identities.

However, another participant stated that they struggle in their approach to clients who identify as sexual minorities, stating: "I may do my clients a disservice by not making the space comfortable for sexual minorities." This participant did not elaborate on what makes them suspect that the space may not be comfortable for sexual minorities, but their sense that this does their clients a disservice could indicate that the therapist recognizes that their own discomfort

and hesitancy to approach topics of sex and sexuality can create a barrier to client discussion of those topics.

Analysis of the data from survey Question #8, which asked participants what training they have received related to topics of sex and sexuality, revealed a wide range between the different participants. One therapist reported that they had received no training, while two others reported that their only training had been during graduate school. As our literature review found, lack of knowledge or training on the part of the therapist can create a barrier to discussion of these topics in sessions with clients (Gill & Hough, 2007; Singh, Boyd, & Whitman, 2010). However, four participants noted that they had specialized training or experience regarding working with clients who identify as LGBTQIA. And one participant reported that they "train and teach on the subject," while another reported that they are a registered sex therapist.

Additionally, analysis of the data collected from survey Question #9 suggests that many of the therapists who responded to our survey identified cultural affiliations which have influenced their experiences in discussing topics of sex and sexuality with clients. Four of the nine participants who responded to this question reported that they identify as members of the LGBTQIA community, which could contribute to an increased openness and comfort level discussing certain topics with clients if therapists themselves have personal experience with such topics. Only one participant indicated an aspect of their cultural background which they cite as a potential barrier to their discussion of these topics with clients: Participant A reported "My family was not comfortable talking about sex and sexuality which has influenced my discomfort."

Analyzing the artwork created by the interview participant, we immediately noted the participant's use of a door as a symbol for barriers to discussion of sex and sexuality in therapy. The participant was given the directive "How does art therapy create a space in which clients can open up about sex, sexuality, and sexual identity?" Discussing the artwork that she created, the participant stated "the door is closed, so you do have to very intentionally open it." The door itself represents many of the barriers to discussion of such topics, which the participant went into further detail about earlier in the interview. But the intentionality that she indicates is required to open the door appears to suggest that another barrier to be overcome is the therapist's own willingness to engage with clients in discussion of these topics. The participant explained that she views the opening of the door to be a joint effort that requires the work of both the client and the therapist.

The door is drawn with solid, thick black marker lines. Although the interview participant talked about the idea of opening the door, in the drawing the door is not open even a crack yet, but is instead firmly closed. This echoes the participant's emphasis on the need for intentionality to open the door, it is not already open and it does not appear that it will swing open of its own accord. The colorful lines drawn around the edges of the door and the door knob seem to represent the topics of sex, sexuality, and sexual identity, which the participant described as "a beautiful, chaotic mess. Exquisite." Not only is the door a barrier to this "beautiful, chaotic mess," but the very lines themselves that create the door are a barrier to the colorful lines which do not cross the dark, solid lines of the door.

The baseline that the door is drawn upon also creates another visual barrier in the drawing, as the space below it takes up approximately a third of the page, but was left empty.

The participant pointed this out when discussing her artwork after its creation, stating: “This could be the therapy too [gestures to the blank space in the lower half of the drawing], it’s just clean, you know? Or you can walk here [points to the door in the center of the drawing]. I’s almost like there’s a choice.” Thus indicating that another potential barrier to discussion of these topics in therapy is the therapist’s own choice to talk about or not talk about them. The participant also noted that while art therapy can help break down barriers to such discussion, the use of art to talk about sexuality could also create a new barrier if these topics come up in the artwork but are not further discussed, as she stated: “You could actually explore all of this visually and non-verbally and then never talk about it.” This again echoes the idea of “intentionality” which she brought up earlier, emphasizing that overcoming barriers to discussion of these topics, even with the aid of art therapy, requires conscious choice and willingness on the part of the therapist.

Analysis of the entirety of the interview, including both points at which the participant was directly asked about barriers to discussion of these topics in sessions, and points at which she brought up barriers in response to other questions, lead us to identify the following barriers cited by the participant: Client concerns for safety; shame and cultural or religious norms; client privilege; therapist discomfort with such discussion; therapists not asking clients directly about sex and sexuality; assumptions about a client’s gender, sexual orientation, or relationship(s); and “outdated” and “heteronormative” education on these topics. The participant noted that her coworkers have asked her “why is it that you always get all the gay clients?” but the participant believes it is possible that the reason she appears to have more LGBTQIA clients than her colleagues is because she asks her clients directly about their sexuality, which leads to them

disclosing information about their sexual identities which they may not disclose to a therapist who does not ask about it.

Although not directly identified by the participant as a barrier, her discussion of the different geographic locations in which she has practiced appear to indicate that where clients live can also be a potential barrier to discussion of sex and sexuality. As evidenced by her report of how clients living in a more conservative area approach the topic of polyamory, as opposed to clients living in a more liberal area, what clients perceive as socially acceptable to talk about can be influenced by the environment they live in, and the culture they are surrounded by. This likely extends into the therapeutic environment as well, as the outside cultural and social norms of a geographic area may influence how clients expect to be perceived by their therapist, what they expect their therapist's own values to be, and what they feel they can safely discuss or disclose in the therapy session.

Discussion of Findings and Meanings

This research project emerged from the understanding that sex and sexuality are still considered taboo subjects by our society. Even within the therapeutic environment there remain barriers to disclosure and discussion of these topics. Love & Farber (2017) noted that it can be challenging for both therapists and clients to bring up these topics. For LGBTQIA clients in particular, historical uses of "conversion therapy" (Hogan, 2012) and personal experiences of judgment, microaggressions, homophobia, or other negative experiences in therapy or other healthcare settings can make clients especially cautious about disclosing their sexual or gender identities (Magee & Spangaro, 2017). As students studying to become art therapists, the goal of our research was to explore how art therapy can help overcome those barriers and facilitate

discussions of sex and sexuality. The data we collected and analyzed from practicing art therapists revealed ways in which these therapists have used both art and other approaches to open up conversations about sex and sexuality, as well as ways in which therapists' own comfort level with these topics can maintain barriers to such discussion.

In this section, we will explore our research findings and the emergent themes that we discovered . We will begin by discussing our findings regarding how art therapy can help facilitate discussions of sex and sexuality in sessions with clients. Then we will explore our findings from participants' discussions of their education and training in regards to these topics. Expanding upon that, we will consider our findings regarding how therapists' levels of comfort or discomfort affect their discussions of sex and sexuality with clients. Additionally, we will discuss our observations from the data regarding therapists' own sexual identities and cultural background as it pertains to their comfort level with these topics, linking our findings back to the original research we looked at when beginning this project.

How Art Therapy facilitates discussions of sex and sexuality.

Our research revealed that art therapy can be beneficial in helping clients explore and discuss topics of sex and sexuality in their therapy sessions, but the art therapist's role in this process is just as important of that of the art itself. This echoes Rubin's (2016) emphasis on the importance of collaboration, as "therapist and patient work together toward understanding" (p. 74). Art therapists must be comfortable and knowledgeable about these topics in order to help clients talk about them both verbally or nonverbally through the art.

While some participants who responded to our survey reported ways in which art-making supported and facilitated their clients' exploration of sex and sexuality, others reported that they

had little or no experience using art to explore these topics in sessions. Of the therapists who responded that they do use art to aid in discussions of sex and sexuality, commonalities between them included the exploration of identity through art, and the use of art-making in couples treatment. Considerations such as the types of directives used and the ability of art-making to provide a sense of containment were also brought up by a few participants. Three of the survey participants specifically mentioned the use of art making to process trauma, which could reflect the fact that the majority of the research within the art therapy field on the use of art in relation to sex and sexuality has focused on sexual trauma.

It appears that while some art therapists have had success in using art therapy techniques to facilitate exploration and discussion of sex and sexuality in sessions with clients, other art therapists have had very different experiences, with limited conversation about these topics with clients either verbally or through art-making. This suggests that although art therapy can be a valuable tool in helping clients talk about and explore their feelings regarding sex, sexuality, and sexual identity, the art therapists themselves must first be comfortable with these subjects before that exploration can come about. The interview participant articulated the necessity of this comfort level to support the art-making when she said "you could actually explore all of this visually and non-verbally and then never talk about it." This also brings up the importance of discussion of the art in order to understand the client's meaning, as Wadeson (1987) pointed out that a client's artwork may not make sense to the therapist, or the therapist may interpret the art incorrectly without the client's explanation of it (p. 78-79). Art-making can help clients explore their sexuality and sexual identities in ways that talk therapy alone could fall short at times, but comfort with these topics must go hand in hand with the art. Art therapists need to be

comfortable, experienced, and knowledgeable about the ideas about sex and sexuality that can emerge from the art in order to truly help and support their clients.

When asked about their approach to clients who identify as sexual minorities, only one responder specified that they use "clues" in their office to communicate their openness and affirmative stance to clients - an idea we found multiple recommendations for in the literature on creating an affirmative therapeutic space for LGBT clients (Magee & Spangaro, 2017; McGeorge & Carlson, 2011; Shelton & Delgado-Romero, 2011; and Singh, Boyd, & Whitman, 2010). None of the participants mentioned how they communicate an affirmative stance through the art materials, such as making sure to have inclusive images in collage boxes, as suggested by Brody (1996) and Addison (1996). Many of the participants reported that they are "open" but did not clarify how they communicate this openness to their clients. It is possible that if we had asked how they communicate this they may have elaborated on this, however, in the data we collected, most participants merely stated that they approach their clinical practice with an open mind, but did not specify how they make that clear to clients. But as Magee & Spangaro (2017) pointed out, therapists who advertise that they are LGBTQIA-friendly are more likely to find that clients will engage in the therapeutic process and disclose their sexual orientation (p. 351)

Barriers presented by the nature of the topic.

Something that stood out to us during the process of data collection was the difficulty in recruiting participants for both our survey and focus group. We speculate that this could be due to several factors: First, participants' available time for involvement in this research may have posed a barrier to their participation. We observed that while we received eleven responses to the likert scale questions in the first half of our qualtrics survey, we only received nine responses to

the open ended responses in the second half of the survey. It is possible that this is also due to time, as participants may have found it easy and quick to answer likert scale questions, but as they progressed in the survey, may have determined that they did not have time to continue answering open ended answers on such a nuanced topic.

However, it is also possible that because the topic of sex and sexuality is such a socially taboo subject, that very taboo may have also dissuaded individuals from participating in this research. And answering open ended questions about these topics and their experience discussing them with clients may have brought up some discomfort for the two participants that dropped out of the survey after the likert scale questions. It is also possible that open discussion of sex and sexuality may go against the norms of a specific culture that potential participants identify with, which could have also dissuaded them from participating in this research to begin with. So while our difficulty in recruiting participants could be attributed to availability and scheduling, it could also reaffirm that this is a subject that is difficult for people to talk about, and one that that many individuals are not comfortable with, or have not received enough education to possess the language to talk about. This as supported by much of the research we looked at that explored the taboos and stigma around these topics, and the shame that creates barriers to conversations about them (Bauman & Hill, 2016; Foucault, 1978; Love & Farber, 2017; Pukall, 2009).

In our data collection, two participants provided us with artwork made from what appears to be fine motor materials. One survey participant uploaded an image that is created from what appears to be a pencil, and the interview participant drew a picture with colored markers. Although the materials used are different, both images maintain similar formal qualities, as previously discussed in the data analysis section of this paper. However, we noticed that the

content of the artwork may allude to similar themes as well. Both images contain what could appear to be something of a barrier. In the image rendered in pencil, this is represented by an amorphous hill-shaped object, towering over a smaller shape. In the marker drawing, the central image is was described by the interview participant as a door. Both of these images could suggest a barricade, or sense of being closed off, when it comes to discussion about sex and sexuality in the therapeutic space. The interview participant's commentary on her art response clarifies that she did indeed choose to depict a door as a barrier - one that must be opened by both therapist and client, in order for discussions about sex and sexuality to occur.

Therapist education and training on topics of sex and sexuality.

Another theme that emerged from our analysis of the data is a significant lack of knowledge and education about certain topics or sexual identities as reported by the therapists we surveyed. As these are subjects which are often misunderstood or stigmatized in society at large, it is important for therapists to become knowledgeable about them in order to best serve their clients. The literature we reviewed on this topic emphasized the importance of such education, but also noted that many therapists have little or no training in this area (McGeorge & Carlson, 2011; Singh, Boyd, & Whitman, 2010). Our interview participant reported that she did not remember taking any courses that addressed sexuality, and several of our survey participants reported that the amount of training they had received was "none," "little to none," or limited to one class. It is possible that this limited education stems from the same social and cultural stigma and taboos surrounding these subjects, and although graduate programs may be making efforts to include more of these topics in their curricula, therapists could still benefit from a great deal more education, as both Kahn (2013) and Metzl (2017) note in their research that students

graduating from art therapy programs are still hesitant to discuss sexuality in their clinical practices.

This reported lack of training among art therapists indicates to us that there is a strong need for more education on the topics of sexuality and sexual identity, both at the graduate level and post graduation and licensure. Further training and experience is particularly important if these are topics that therapists have not taken undergraduate or graduate classes on, or topics they have culturally been sheltered from or avoided in their personal lives. Although it appears from some of our participants' responses that training opportunities may exist for those who seek them out, all art therapists would benefit from such trainings, even (or especially) those who may not seek them out. Factors that could influence interest in seeking out such trainings could include whether a clinician is actively working with clients addressing these issues or not, is not practicing in a location that is convenient to accessing in-person trainings, or does not know how or where to access these trainings online or in person. As evidenced by our interview participant's report of how she educated herself on these topics through books, TED Talks, and podcasts, it is also possible for therapists to find further information on these topics outside of the art therapy and marriage and family therapy realms. But like the availability of additional trainings, these resources, although they are readily available to the public, may not be accessed by therapists unless they are particularly motivated to seek them out.

The art therapists who reported the highest levels of experience and comfort with these topics appeared to also be ones who sought out trainings, research, and other educating opportunities on their own because of their interest and passion in these topics. When asked, the topics that participants expressed the most interest in when learning more about about included

BDSM/kink, non-monogamy, sexual pleasure, and sexual dysfunction. This is consistent with the findings of the literature we reviewed, as Witzman (2006) noted that most mental health training programs do not teach students about non-monogamous relationships, and Pillai-Friedman et al. (2015) noted a lack of education among therapists regarding BDSM and kink practices. Other researchers also pointed out that most of the materials used in graduate programs generally have a heteronormative bias (Gochros, 1986; Love & Farber, 2017).

Our interview participant identified this limitation as well, stating that "Every fucking book we read is so hetero, like everything!" She also went on to talk about the lack of training and education provided for therapists even after they leave school and become licensed, stating that such training "should be just one of the mandatory parts of getting your license every two years again, it should be like law and ethics… If they've never exposed themselves and if they don't feel comfortable having those conversations then, I mean they just need to go and have them, but that's easier said than done, right?" Although she reported both a high level of comfort and experience with many topics related to sex and sexuality, she also emphasized her interest in the subject, and her eagerness to continue educating herself: "I'm learning something every day."

Therapist comfort level with discussions of sex and sexuality.

Although the interview participant spoke more on the subject of clients' comfort levels when it comes to discussing sexuality in the therapeutic space, she echoed the literature indicating that sexuality is a societally taboo topic of conversation, and the shame associated within that conversation can influence the comfort or discomfort in the space (Gochros, 1986; Harris & Hays, 2008; Metzl, 2017). The interview participant stated: "I think we have a long ways to go for it to just be integrated into even a master's program… It's like the world has to

change for therapists to get there too." This again emphasizes the heteronormative bias of the dominant culture which exerts its influence on even the therapeutic space (Hogan, 2012; McGeorge & Carlson, 2009; Shelton & Delgado-Romero, 2011).

As we noted before, the interview participant stated that she attributes much of her own personal comfort with discussing sex and sexuality with clients to her familiarity with having these conversations, as she identifies as a member of the LGBTQIA+ community, and has educated herself on those topics and thus feels more comfortable integrating them into her practice. She stated "I think that, when it comes to sexuality, it's obviously something personally I've been very used to having to have that conversation, and so then I bring it up pretty early on in my intake process." She also went on to name books she has read that contributed to her education on these subjects: "I love Esther Perel, *Mating in Captivity*, and *Ethical Slut* ... I think because I've read them all, I very comfortably would like include them in my practice."

Looking at the comfort levels reported by our survey participants, it appears possible that some participants may report a high comfort level even when they report limited or no experience working with that population or specific aspect of sexuality. Considering that our data also revealed that most of the art therapists we surveyed reported receiving limited or no training or education on these topics, that lack of education combined with a lack of experience with these topics could result in challenges for these therapists to bring up or explore these topics with clients, despite their reported comfort with them. And even therapists who report feeling comfortable in general with these topics, or with the majority of topics may still experience some discomfort when it comes to specific topics. The literature on this subject also indicates that increased training on these topics contributes to greater comfort and clinical competence (Gill &

Hough, 2007; Reissing & Giulio, 2010), as well as a greater likelihood that therapists will bring up these topics and invite clients to discuss them (Harris & Hays, 2008).

Although our Qualtrics survey was anonymous, there are several factors which could have influenced participants to desire to report a higher comfort level: a desire to feel competent and skilled in their chosen profession, a wish to feel more comfortable than they currently do, a sense of pressure to live up to the standards of the profession, or a reluctance to admit or acknowledge discomfort due to shame or feelings of imposter syndrome. Or, in the case of therapists who have had little to no experience discussing certain topics with clients, their rating of their comfort level may be speculation, but they could find that they feel differently if or when they actually encounter these topics in session. If either of these is the case, then the therapist's lack of experience with a certain topic could still pose a barrier to discussion of the topic in session, even if the therapist reports feeling comfortable discussing it, especially considering how the therapist's own beliefs and biases can affect how they approach these conversations with clients (Gill & Hough, 2007).

Additionally, a more nuanced aspect to therapist comfort level and reporting that we found was therapists' self-report of their comfort level declined when we narrowed our focus to ask about their comfort level regarding specific aspects of sexuality. We speculated that when the terms "sex and sexuality" were presented in the first survey question, asking about overall comfort level, the first thoughts that my have come to mind for our participants may have centered around topics of sexual orientation or sexual trauma, which participants reported having more clinical experience with - and not necessarily topics such as BDSM, kink, and non-monogamy, which they reported less experience with. The literature we reviewed stated that

a lack of research and clinical training regarding working with clients in non-monogamous relationships contributes to therapists being unprepared for the clinical considerations of working with such clients (Girard & Brownlee, 2015; McCoy et al., 2015). And Pillai-Friedman et al. (2015) pointed out that a lack of knowledge about BDSM and kink may contribute to therapists holding misconceptions or stigmatized views about these practices. Our analysis of the survey data showed that even participants who reported being comfortable overall stated that they were less comfortable with certain topics such as BDSM/kink and non-monogamy once they were able to specify their comfort level for each subtopic individually. This suggests that while many therapists may view themselves as comfortable discussing sex and sexuality in a more general, overall sense of these terms, or when it comes to the majority of topics within this broad category of human behaviors, there are still specific topics which some therapists feel somewhat less comfortable with.

Therapist experience level with discussing sex and sexuality in sessions with clients.

We also found interesting trends in comparison of therapists' reported comfort levels and experience levels with specific topics. In regards to some topics such as sexual identity and sexual orientation, sexual trauma, and sexual issues in relationships, therapists reported both high levels of comfort and high levels of experience. Yet when it came to other topics such as non-monogamy and BDSM/kink, therapists reported comfort levels that appear to be significantly higher than their reported experience levels. This could indicate that personal experience with such topics increases therapists' comfort levels even if they do not have as much clinical experience with a particular topic, or it could suggest that therapists believe that, in theory, they may be comfortable with a certain topic but have not been able to assess their

comfort level accurately due to lack of experience working with clients addressing this topic. Harris & Hays (2008) address this, stating that therapist comfort level is often influenced by their experience level. Harris & Hays (2008) also go on to state that they encourage therapists not to avoid gaining experience with these topics, but to continue to strive to gain experience working with client's undergoing sexual issues or needing to speak on these topics in the therapeutic space (p. 286)

Regarding BDSM and kink in particular, the majority of our survey participants rated their comfort level as a "3" or a "4" on a scale of 0 - 5, with 5 being "very comfortable", but rated their experience level with this topic as a "0" or a "1" on a scale of 0 - 5, with 0 being "no experience". This discrepancy between reported comfort level and reported experience level again suggests that therapists may believe themselves to be comfortable with certain topics even though they have limited clinical experience with them. This is also referenced in the literature we looked at, as evidenced by Pillai-Friedman et al.'s research (2015), which noted "some BDSM practitioners found that the therapists misrepresented themselves as kink aware when they were not knowledgeable about BDSM practices and needed to be educated about it" (p. 199). This suggests that clients can tell when therapists lack knowledge or experience about specific topics, such as kink and BDSM, even if they present themselves as comfortable, aware, or affirmative. Pillai-Friedman et al. (2015) also note that therapists inexperienced in working with clients practicing kink and BDSM may experience countertransference when clients discuss these practices, which can affect the therapeutic relationship.

It is possible that a lack of experience with specific topics such as this could also contribute to therapists not asking questions about these topics, or not presenting an affirmative

approach to clients. Although therapists may be working with clients who identify as kinky and practice BDSM, those clients may be hesitant to disclose this to their therapists, as Pillai-Friedman et al. (2015) cited fear of judgment and fear of therapists pathologizing kink as reasons that clients often do not disclose this aspect of their sexuality. Just as our interview participant emphasized that the reason for her "getting all the gay clients" was that she asked about sexual orientation, as opposed to her colleagues who did not ask, the same importance of asking and opening up a conversation likely applies to BDSM and kink as well. Therapists who lack experience with these topics may hesitate to ask those questions, thus creating a self-perpetuating cycle in which their clients do not disclose, and the therapists continue to practice without gaining the experience of discussing these topics with their clients.

Most survey participants indicated that they address these topics in intake - but did not clarify whether this means that they continue to assess them in ongoing therapy. As the literature we reviewed discussed many reasons why clients may be hesitant to disclose or discuss their sexuality with their therapists (Baumann & Hill, 2016; Love & Farber, 2017; Magee & Spangaro, 2017; Sprott et al., 2017), it is probable that such disclosure is even less likely to occur during intake when rapport has not yet been established. We speculate that some therapists may perceive client sex and sexuality to be something separate from the client's actual identity, inhibiting them from having conversations with clients about sex and sexuality because it may not be seen as something pertaining to the whole of the treatment. However, we argue that sex and sexuality are seamlessly part of clients' identities, and should be explored as such. This idea was also referenced in the literature by Gochros (1986), who noted the prevalence of mental

health providers who "consider [sexuality] irrelevant to the mission of the profession or the particular job" (p. 8).

In Question #7 of our Qualtrics survey, several participants expressed utilizing the art therapy process to address sex and sexuality through identity exploration. Participant B reported using "art making with queer youth/identity formation… mask making and self portraits. And Participant G stated that they utilize art-making by "asking clients to draw thoughts and feelings about identity." This reinforces the idea that sex and sexuality are not an aspect of identity that needs to be integrated in and treated separately, but a consistent piece within a client's identity. When we asked our survey participants what topics they would like to learn more about, a high number identified topics that they also reported already feeling comfortable about, indicating that they still want to learn more. The topic participants reported the highest interest in learning more about was BDSM/kink, reflecting the data from the earlier question in the survey in which participants reported that this was one of the topics they had the least experience with.

Avoidance.

Another finding that stood out to us was the possibility that there is some avoidance of discussion and utilizing art making to discuss sexuality on the part of art therapists. From the data we collected, it appears that many of the survey participants reported limited discussion of these topics and limited use of art to explore them, which could be attributed to avoidance. We speculate that if avoidance is occuring, it could be due to therapist comfort level; lack of training or education, as stated above; or cultural affiliations that may inhibit the therapist from discussing and addressing aspects of a client's identity pertaining to sexuality. The idea of avoidance also came up in the literature we reviewed, as Love & Farber stated that "discomfort

with these issues, often coupled with a lack of adequate clinical training around sexual topics, may result in avoidance behavior that takes the form of implicit signals to their clients that sexual matters just don't need to be discussed to any great extent in therapy" (p. 1490).

The data we collected also showed that our survey participants' use of art to facilitate conversations about client sex and sexuality can at times be indirect or unintentional, and often not specifically used to address these topics. In response to Question #7, Participant A stated "Sexual trauma and sexuality has been elicited through the art process without intention" and Participant E stated "Most of my clients have not used art to explore sex or sexuality. Occasionally some will use collage to express thoughts and feelings." This indicates that participants are using art making in the therapeutic space, but without encouragement to go in the specific direction of exploring sex and sexuality. And if these topics do emerge through the art, that is more of an unplanned result of the art making process. Participant D stated "n/a" and Participant I stated "not much experience here" in response to Question #7, indicating no usage of the art materials to facilitate these discussions in any way, responses which could also suggest some avoidance of the topic. As we learned from the literature on this subject, a great deal of research has established that clients may be waiting for an invitation from the therapist indicating that it is safe to discuss these topics (Harris & Hays, 2008; Love & Farber, 2017), so art therapists who wait for these topics to come up in the art without making a clear invitation or asking their clients about these topics may find that the client never brings them up either.

Additionally, in response to Question #5, Participant A reported that their limited comfort level and knowledge influences their discussion with clients around sex and sexuality, and stated: "If I educated myself more and gained more experience, I would probably become more

comfortable talking about these subjects with my clients." We suspect this could also indicate a certain level of avoidance, because there are trainings available, if therapists wish to seek them out. Gochros (1986) reflected that avoidance and assumptions about sexuality being irrelevant come from therapist discomfort, which leads to many missed opportunities and interventions within treatment (p. 8). Additionally, Love & Farber (2017), Harris & Hays (2008), and Paprocki (2014) all discussed how therapist discomfort, impairment or incompetence may cause inadequate care of a client due to discomfort or avoidance on the end of the therapist (p. 281).

In contrast to Survey Participant A, the interview participant reported many ways in which she has continued to educate herself on these topics, demonstrating that it is indeed possible for therapists to seek out further training and information if they are motivated. But echoing the literature discussing how societal and cultural stigma shape the personal beliefs and biases of therapists (Gochros, 1986; Love & Farber, 2017), the interview participant also identified that her own queer identity and experience influenced her comfort level with discussions of sex and sexuality. Participant A cited their own cultural background, as they specifically stated "My family was not comfortable talking about sex and sexuality which has influenced my discomfort." This is an important consideration, as the availability of optional further trainings and education may not on their own be enough to overcome a sense of stigma and taboo that some therapists may have been brought up with regarding these topics.

Therapists' own sexual identities and cultural affiliations.

This brings up an additional finding from our research, which resulted from our analysis of our survey participants' self-report of their own cultural identities. In Survey Question #9, we asked survey participants to share any cultural affiliations that they felt might help us as

researchers contextualize their experiences and responses. Four of the nine survey participants who completed all of the open-ended questions identified as members of the LGBTQIA community, and our interview participant also self-identified as queer. Analyzing the data, we noticed a strong correlation between identifying as LGBTQIA and reporting a high comfort level with discussing the topics of sex and sexuality with clients.

It is likely that being a member of the LGBTQIA community contributes to a therapist's comfort and familiarity of discussing topics related to sexuality and sexual identity, as these are topics they have probably reflected on and discussed with others in their personal lives before they became therapists. Our interview participant articulated this, saying: "when it comes to sexuality, it's obviously something personally I've been very used to having to have that conversation." And two of the survey participants referenced their own LGBTQIA identities in discussing their own approaches to working with clients who identify as sexual minorities.

Because the percentage of our participants who identify as LGBTQIA is significantly higher than estimated percentages of LGBTQIA individuals in the general population of the United States (Newport, 2018), we considered the possibility that the very nature of our research topic may have created a self-selecting survey: Therapists who identify as LGBTQIA and have a higher comfort level addressing topics of sex and sexuality in therapy with clients may have been more likely to choose to respond to our survey precisely because of their comfort level with these topics. Similarly, even therapists who do not identify as members of the LGBTQIA community may have chosen to respond because these are topics they feel comfortable, are interested in, or have a higher level of knowledge or education in. But therapists who have less comfort or

experience with these subjects may have been less inclined to respond to the survey because of the nature of the topics that it covered.

Limitations & Suggestions for Future Research

Despite the success we had with gathering data through our survey and the individual interview, there were some notable limitations to our research: The first limitation that widely influenced our data collection was the fact that our survey and interview participants were accrued only through LMU alumni via email. This limitation was significant, as it not only provided us with a smaller pool of art therapists to recruit participants from, but the invitation to our survey was also sent out to alumni at a time when other LMU students were also sending out surveys recruiting responses for their research as well. It is possible that the multiple surveys LMU alumni were invited to participate in at the same time may have influenced their willingness to participate in our survey and focus group, particularly if they had already responded to another research group's survey. Furthermore, the data that we did collect from our participants only demonstrates the experiences of art therapists who have graduated from LMU's art therapy program, while the national and international field of art therapy is comprised of therapists who have received their degrees from a variety of institutions, and likely had very different experiences and training in regards to these topics.

While we kept our survey short, due to concerns that a longer survey requiring more time from the participants might dissuade many from responding, the small number of questions we asked did limit the quality of the data that we were able to collect. It is very possible that given the limitations we faced in recruiting participants, a longer survey would have resulted in even fewer responses and less data. But it would have been beneficial to our analysis of the data if we

had been able to obtain more information, or go into more depth on some of the topics we asked our participants about, as reviewing the data later often left us wishing we could ask follow-up questions of our survey participants.

Another limitation to our research was the lack of interest in focus group participation from the survey participants. Although two participants expressed interest in joining a focus group, unfortunately one of them was unable to meet at any of the available times we offered, so we had to alter our original plan, and instead conducted an interview with the one available participant. When we conducted this interview, our participant requested to use Skype, an internet based live video, due to being unable to travel to the LMU campus to do the interview in person. The use of Skype was successful, however, internet connection varied from computer to computer, causing some lag or delay in communication at times throughout the interview, factors which would not have been present had we done the interview in person.

Conducting the interview via internet may have also influenced the art response portion of the data, as the interview participant may have felt uncomfortable making art with two researchers watching her through the computer. Additionally, the use of the internet to conduct this portion of the interview was limiting as the participant may have had fewer art materials available to utilize than the researchers would have chosen to provide had we conducted the interview on campus. The angle of the camera also prevented us from watching the art-making process, so the data we collected from the participant's art response did not include observation of her process.

Although we hoped that soliciting art responses from our survey participants would contribute a greater level of depth to our data, only two out of the eleven survey participants

created and submitted artwork. It is possible that this is attributable to participants not having time to complete an art directive in addition to answering the preceding questions. Additionally, participants may not have had art materials readily available with which to create a response piece. It is also possible that even if participants had access to art materials at the time that they were taking the survey, they may not have been had the technological ability to photograph or scan artwork to upload to Qualtrics, or this may have been an extra challenge which dissuaded them from creating artwork. Another limitation to this data is that our survey did not ask participants to include a statement about their art response, so the information we were able to glean from the art was limited without hearing the participant's own interpretation of it. Art-making from both our survey and our focus group proved to be a limitation in our research, as these few and limited responses do not allow us to draw any conclusive themes about the artwork and its relation to sexuality.

Finally, a limitation that may have influenced our data is the nature of the topic of sexuality. For some individuals, speaking about sex is considered taboo or may feel uncomfortable, traumatizing, or re-traumatizing. For participants, it is possible that any of the previously mentioned reasons may have influenced responses, or limited their experience working with clients discussing these topics. This also may have discouraged potential participants from taking the survey, as it is possible they may have felt their inexperience or discomfort would have rendered their responses unusable or invaluable. Or they may have felt uncomfortable answering questions about sexuality, even anonymously. Due to self-selection bias, it is also possible that the majority of the participants who responded to the survey were therapists who are interested in and feel comfortable talking about sex and sexuality. So our data

may reflect this, and is likely more biased than it would have been if participants had not known what the topic of the survey was before they responded to it.

We hope that future research will continue to explore these topics, and we suggest that researchers interested in this subject seek to collect data from a larger number of subjects, as our small subject pool was a significant limitation to our research. Research expanding beyond the scope of LMU's alumni would also be beneficial to the art therapy field, to explore and learn from the experiences of art therapists who graduated from different universities and received different types of training, to identify what types of training and education are most helpful to therapists in this regard. Additionally, although it was beyond the scope of our own research at this time, we suggest that future researchers seek to collect data from clients themselves, to learn about their own lived experiences addressing topics of sex and sexuality in therapy, and how art therapy specifically has influenced their disclosure, discussion, and exploration of these topics.

Conclusion

Our research set out to explore how art therapists can use art making to help facilitate discussions of sex and sexuality in sessions with clients. We collected survey responses from practicing art therapists and conducted an interview with a practicing art therapist to hear about their lived experiences addressing these subjects with clients both verbally and non-verbally through art-making. While the number of participants we were able to recruit was limited, their responses revealed valuable information regarding the benefits of art therapy and the barriers that still exist when it comes to discussion of sex and sexuality in a therapeutic setting.

The questions that guided our research were: (1) How do art therapists use art therapy techniques, materials, and directives to create a therapeutic environment in which clients can open up about their sexuality? (2) How comfortable and/or experienced are therapists regarding discussion of topics related to sex and sexuality with clients in therapy sessions? (3) What barriers are there to discussing sexuality in therapy, and how does art help overcome those barriers?

Through analysis of the data we collected through our survey and interview, several themes emerged: Still-existing barriers to discussion of topics of sex and sexuality in therapy, the importance of art therapists' own comfort level and knowledge of specific topics related to sex and sexuality, limitations in graduate school education and post-licensure training regarding these topics, and how art therapists' own personal backgrounds and cultural affiliations can contribute to their comfort level with these topics. While therapists we surveyed and interviewed named ways art-making has helped their clients to explore these topics, it is clear that the art therapist's role in this process is important, their intention, and their comfort level addressing

these topics likely determines how art-making is used to explore them, and how the therapist and client discuss the art and its meaning in regards to the client's sexuality.

We hope that identifying these themes will help art therapists think about how they utilize art-making to help clients explore sex and sxuality in their own practice, and encourage therapists to continue learning about these topics. We also hope this will inspire further conversation and research on these subjects, to increase the art therapy field's understanding and use of art therapy to explore sex and sexuality.

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Appendix A

Paterson, Julie <Julianne.Paterson@lmu.edu> Mon, Dec 3, 2018 at 7:53 AM
To: Allison Marx <allison.r.marx@gmail.com>, Lia Verzatt <liaverzatt@gmail.com>
Cc: "Bianchi, Jessica" <Jessica.Bianchi@lmu.edu>, "Moffet, David" <David.Moffet@lmu.edu>, "Reilly, Elizabeth" <Elizabeth.Reilly@lmu.edu>, "Weaver, Kathleen" <kat.weaver@lmu.edu>, "Paterson, Julie" <Julianne.Paterson@lmu.edu>

Dear Ms. Marx and Ms. Verzatt,

Thank you for submitting your IRB application for your protocol titled ***Creating the Therapeutic Environment: An Exploration of Art Therapy and Sexuality***. All documents have been received and reviewed, and I am pleased to inform you that your study has been approved.

The effective date of your approval is **December 3, 2018 – December 2, 2019**. If you wish to continue your project beyond the effective period, you must submit a renewal application to the IRB **prior to November 1, 2019.** In addition, if there are any changes to your protocol, you are required to submit an addendum application.

For any further communication regarding your approved study, please reference your **new IRB protocol number**: **LMU IRB 2018 FA 48.**

Best wishes for a successful research project.

Sincerely,

Julie Paterson

Julie Paterson I Senior Compliance Coordinator I Loyola Marymount University I 1 LMU Drive I University Hall #1718 I Los Angeles, CA 90045 I (310) 258-5465

Appendix B

Dear Fellow Art Therapists,

Thank you in advance for your consideration in being involved in the following Masters Research Project. If you have experience working with clients discussing and exploring sexuality, sexual identity, and other topics related to sex, or have other relevant experience that you would be willing to discuss with us – we would appreciate your help!

We are researching how art therapy is used to create a safe space in which clients can open up about their sexual identities and experiences. We would like to invite you to participate in an anonymous Qualtrics online questionnaire exploring your experience addressing these topics in therapy with clients.

Link to Survey: http://mylmu.co1.qualtrics.com/jfe/form/SV_832ep3QCP8nZ1TD

This survey is 12 questions long and will take no longer than 15 minutes. The results of this survey will be used to complete our final research project in our Master's degree program. The final paper will be posted on LMU's Digital Commons website where it will be available to the public.

We will also be holding a focus group at a later date, and would greatly appreciate participation in this event. Please indicate your interest at the end of the questionnaire and we will contact you with further details and to schedule a date and time. The focus group will be held at the LMU campus in Los Angeles, in the MFT department suite, and will be approximately one hour. Light refreshments will be provided.

The Research Team,
Allison Marx - amarx4@lion.lmu.edu
Lia Verzatt - lverzatt@lion.lmu.edu
Faculty Sponsor: Jessica Bianchi

Dept. of Marital and Family Therapy / Art Therapy
Loyola Marymount University

Appendix C

LOYOLA MARYMOUNT UNIVERSITY

Experimental Subjects Bill of Rights

Pursuant to California Health and Safety Code §24172, I understand that I have the following rights as a participant in a research study:

1. I will be informed of the nature and purpose of the experiment.

2. I will be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be utilized.

3. I will be given a description of any attendant discomforts and risks to be reasonably expected from the study.

4. I will be given an explanation of any benefits to be expected from the study, if applicable.

5. I will be given a disclosure of any appropriate alternative procedures, drugs or devices that might be advantageous and their relative risks and benefits.

6. I will be informed of the avenues of medical treatment, if any, available after the study is completed if complications should arise.

7. I will be given an opportunity to ask any questions concerning the study or the procedures involved.

8. I will be instructed that consent to participate in the research study may be withdrawn at any time and that I may discontinue participation in the study without prejudice to me.

9. I will be given a copy of the signed and dated written consent form.

10. I will be given the opportunity to decide to consent or not to consent to the study without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on my decision.

Appendix D

LOYOLA MARYMOUNT UNIVERSITY

Informed Consent Form: Qualtrics Survey

Date of Preparation: November 18th, 2018

Loyola Marymount University

Creating the Therapeutic Environment: An Exploration of Art Therapy and Sexuality

1) I hereby authorize Allison Marx and Lia Verzatt to include me in the following research study: Creating the Therapeutic Environment: An Exploration of Art Therapy and Sexuality.

2) I have been asked to participate on a research project which is designed to examine how art therapists create a safe space for clients to discuss and explore sexuality, sexual identity, and sexual experiences or issues in their lives. This procedure will last for approximately 15 minutes.

3) It has been explained to me that the reason for my inclusion in this project is that I am a practicing art therapist who has worked with clients discussing and exploring sexuality, sexual identity, and/or sexual experiences and issues.

4) I understand that if I am a subject, I will participate in a one-time online questionnaire which includes questions about my experiences as an art therapist helping clients explore sexuality and sexual identity, as well as questions about my personal experiences in therapy. There will also be an art-making component to the questionnaire.

   The investigators will collect responses to the questionnaires through Qualtrics. Data collected for this study will be kept confidential to the extent allowed by law and digitally stored in a computer only the researcher or research mentor has access to. Data will be discarded two years after the study is completed. The results of the research study will be used for the investigators' final research project which will be posted on LMU's Digital Commons website. Results from this study may also be used in possible scholarly publications at some point in the future. In case of publication my name will not be used, and my identifying information will be concealed/protected.

   These procedures have been explained to me by Allison Marx, MFT-ATR Trainee, and Lia Verzatt, MFT-ATR Trainee.

5) I may choose to give my permission for the researchers to use photographs of the images I create as part of this procedure. I understand that I can decline to give

this permission and I can still participate in the study.

Please initial:

____ Yes, I give my permission for images of my artwork to be used.
____ No, I do NOT give permission for images of my artwork to be used.

6) I understand that the study described above may involve the following risks and/or discomforts:
   a) Discussing information that may be culturally taboo and might cause some discomfort.
   b) Discussing challenging experiences when working with Client's sexuality.
   c) Discussing client and therapist sexual traumas or unpleasant experiences, respectively.
   d) Creating, sharing, and discussing artwork pertaining to sexuality.

7) I also understand that the possible benefits of the study are
   a) Learning new approaches to addressing sexuality with clients.
   b) Adding to the research by way of offering alternate strategies and techniques that utilize non-verbal therapeutic approaches through art making when addressing sexuality with clients.
   c) More research regarding how to create a safe, comfortable space for client's to discuss sexuality.
   d) Creating connections and possible resources to provide to clients.

8) I understand that Allison Marx who can be reached at amarx4@lion.lmu.edu or 917.330.9747, Lia Verzatt who can be reached at lverzatt@lion.lmu.edu or 530.574.0788, and Jessica Bianchi who can be reached at jbianchi@lmu.edu or 480.430.0103 will answer any questions I may have at any time concerning details of the procedures performed as part of this study.

9) If the study design or the use of the information is to be changed, I will be so informed and my consent reobtained.

10) I understand that I have the right to refuse to participate in, or to withdraw from this research at any time without prejudice to (e.g., my future medical care at LMU.)

11) I understand that circumstances may arise which might cause the investigator to terminate my participation before the completion of the study.

12) I understand that no information that identifies me will be released without my separate consent except as specifically required by law.

13) I understand that I have the right to refuse to answer any question that I may not wish to answer

14) I understand that if I have any further questions, comments, or concerns about the study or the informed consent process, I may contact David Moffet, Ph.D. Chair, Institutional Review Board, 1 LMU Drive, Suite 3000, Loyola Marymount University, Los Angeles CA 90045-2659 at david.moffet@lmu.edu.

15) In signing this consent form, I acknowledge receipt of a copy of the form, and a copy of the "Subject's Bill of Rights".

Subject's Signature _____ Date _____

Witness _____ Date _____

Appendix E

LOYOLA MARYMOUNT UNIVERSITY

Informed Consent Form: Focus Group

Date of Preparation: November 18th, 2018

Loyola Marymount University

Creating the Therapeutic Environment: An Exploration of Art Therapy and Sexuality

1) I hereby authorize Allison Marx and Lia Verzatt to include me in the following research study: Creating the Therapeutic Environment: An Exploration of Art Therapy and Sexuality.

2) I have been asked to participate on a research project which is designed to examine how art therapists create a safe space for clients to discuss and explore sexuality, sexual identity, and sexual experiences or issues in their lives. This focus group will last for approximately 2 hours.

3) It has been explained to me that the reason for my inclusion in this project is that I am a practicing art therapist who has worked with clients discussing and exploring sexuality, sexual identity, and/or sexual experiences and issues.

4) I understand that if I am a subject, I will be asked to participate in a focus group. The focus group will include a semi-structured interview and art making.

   The investigators will collect data from my responses to interview questions and artwork I create during the focus group. Data collected for this study will be kept confidential to the extent allowed by law and digitally stored in a password protected computer only the researcher or research mentor has access to. Data will be discarded two years after the study is completed. The results of the research study will be used for the investigators' final research project which will be posted on LMU's Digital Commons website. Results from this study may also be used in possible scholarly publications at some point in the future. In case of publication my name will not be used, and my identifying information will be kept anonymous.

   These procedures have been explained to me by Allison Marx, MFT-ATR Trainee, and Lia Verzatt, MFT-ATR Trainee.

5) I understand that I will be audiotaped in the process of these research procedures. It has been explained to me that these tapes will be used for teaching and/or research purposes only and that my identity will not be disclosed. I have been assured that the tapes will be destroyed after their use in

this research project is completed. I understand that I have the right to review the tapes made as part of the study to determine whether they should be edited or erased in whole or in part.

6) I may choose to give my permission for the researchers to use photographs of the images I create as part of this procedure. I understand that I can decline to give this permission and I can still participate in the study.

Please initial:

____ Yes, I give my permission for images of my artwork to be used.
____ No, I do NOT give permission for images of my artwork to be used.

7) I understand that the study described above may involve the following risks and/or discomforts:
   a) Discussing information that may be culturally taboo
   b) Discussing challenging experiences when working with Client's sexuality
   c) Discussing client and therapist sexual traumas or unpleasant experiences, respectively
   d) Creating, sharing, and discussing artwork pertaining to sexuality

8) I also understand that the possible benefits of the study are
   a) Learning new approaches to addressing sexuality with clients.
   b) Adding to research regarding how to utilize art for a client experiencing issues with sexuality.
   c) More research regarding how to create a safe, comfortable space for client's to discuss sexuality.
   d) Creating connections and possible resources to provide to clients.
   e) Having the chance to talk out loud about these topics with other therapists and feeling a sense of community.

9) I understand that Allison Marx who can be reached at amarx4@lion.lmu.edu or 917.330.9747, Lia Verzatt who can be reached at lverzatt@lion.lmu.edu or 530.574.0788, and Jessica Bianchi who can be reached at 480.430.0103 will answer any questions I may have at any time concerning details of the procedures performed as part of this study.

10) If the study design or the use of the information is to be changed, I will be so informed and my consent reobtained.

11) I understand that I have the right to refuse to participate in, or to withdraw from this research at any time without prejudice to (e.g., my future medical care at LMU.)

12) I understand that circumstances may arise which might cause the investigator to

terminate my participation before the completion of the study.

13) I understand that no information that identifies me will be released without my separate consent except as specifically required by law.

14) I understand that I have the right to refuse to answer any question that I may not wish to answer.

15) I understand that if I have any further questions, comments, or concerns about the study or the informed consent process, I may contact David Moffet, Ph.D. Chair, Institutional Review Board, 1 LMU Drive, Suite 3000, Loyola Marymount University, Los Angeles CA 90045-2659 at david.moffet@lmu.edu.

16) In signing this consent form, I acknowledge receipt of a copy of the form, and a copy of the "Subject's Bill of Rights".

Subject's Signature _____ Date _____

Witness _____ Date _____

Appendix F

QUALTRICS SURVEY QUESTIONS:

1. Overall, what is your comfort level with discussions of sex and sexuality in sessions with clients?

0 1 2 3 4 5
Uncomfortable Very comfortable

2. To what degree do you have experience talking about the following *topics* related to sex and sexuality in sessions with clients? 0 being not at all, to 5 being very experienced/expert

___ Sexual identity/sexual orientation
___ Non-monogamous/open/polyamorous relationships
___ Sexual pleasure
___ Pornography
___ Sexual dysfunction
___ BDSM/kink
___ Sexual trauma
___ Masturbation
___ Sexual issues in relationships

3. To what degree are you comfortable talking about the following *topics* related to sex and sexuality in sessions with clients? 0 being not at all, to 5 being very comfortable.

___ Sexual identity/sexual orientation
___ Non-monogamous/open/polyamorous relationships
___ Sexual pleasure
___ Pornography
___ Sexual dysfunction
___ BDSM/kink
___ Sexual trauma
___ Masturbation
___ Sexual issues in relationships

4. To what degree do you have experience working with clients who identify as the following? 0 being no experience, 5 being a great deal of experience.

___ Gay/Lesbian
___ Gender non-conforming
___ Bisexual
___ Non-monogamous
___ Asexual
___ Polyamorous
___ Transgender
___ Kinky
___ None of the above
___ Other sexual orientation or identity

If “other sexual orientation or identity” please specify: _____

5. Describe your experiences discussing sex and sexuality in sessions with clients, including how these topics have been brought up, successes, challenges, and barriers.

6. What is your approach to clients who identify as sexual minorities, such as LGBTQIA clients?

7. Describe the role art making has played in your clients’ explorations of sex and sexuality in sessions.

8. What training have you received related to topics of sex and sexuality?

9. If you feel any cultural affiliations might help us contextualize your experiences (e.g. your age, gender, ethnicity, sexual orientation, etc.), please include those here.

10. What was your interest or motivation in taking this survey?

11. What topics do you think would be helpful for you to learn more about? (select as many as apply)

- ▢ Sexual identity/sexual orientation
- ▢ Sexual pleasure
- ▢ Sexual dysfunction
- ▢ Sexual trauma
- ▢ Sexual issues in relationships
- ▢ Non-monogamous/open/polyamorous relationships
- ▢ Pornography
- ▢ BDSM/kink
- ▢ Masturbation
- ▢ None of the above

12. *OPTIONAL:* Art Directive:
Create a piece of art that shows what discussing topics of sex, sexual identity, and sexuality in session with clients is like for you.
Please upload your image below:

Focus Group Interest:
If you are willing to participate in a focus group about this topic, please include your name, email address and/or phone number so that we may contact you to schedule a date and time.
Providing your contact information here will not be linked to your previous responses which will be kept anonymous.

Appendix G

FOCUS GROUP QUESTIONS:

1. What populations do you work with?

2. What kind of experience have you had discussing sex and sexuality with clients? And what aspects of sexuality have you discussed with clients?

3. What topics related to sex and sexuality do you feel knowledgeable/informed/educated about?

4. How did the classes you took for your degree inform and prepare you for discussing these topics with clients?

5. Are there any types of clients you would *not* be willing to work with, or would not feel qualified to work with, or any topics you would not feel comfortable discussing with a client? What/why?

6. In your experience, how have clients approached disclosing things about their sexuality or sexual identity in therapy?

7. What challenges or barriers do you see making it difficult for clients to open up about these topics?

8. What kinds of art directives and materials have you used to help clients explore their sexuality or sexual identity?

9. In your experiences and observations, has art-making helped clients to talk about sex and sexuality in therapy? How?

10. How have your cultural beliefs, biases, or experiences affected your views of sex and sexuality?

11. How do you think art therapists could improve their knowledge or skills when it comes to exploring topics of sex and sexuality?

12. Art Directive:
Create a piece of art that shows how art therapy creates a space for clients to open up about sex, sexuality, and sexual identity.

Appendix H

COUNSELING SERVICES AND SEXUALITY-RELATED RESOURCES

Airport Marina Counseling Services
https://www.amcshelps.com/
7891 La Tijera Blvd
Los Angeles, CA 90045
310.670.1410

Didi Hirsch Mental Health Services
Suicide Prevention Lifeline
800.273.8255
http://www.didihirsch.org/suicide-prevention-lifeline

Los Angeles LGBT Center
https://lalgbtcenter.org/
1625 Schrader Blvd
Los Angeles, CA 90028
323.993.7400

Planned Parenthood Santa Monica
https://www.plannedparenthood.org/planned-parenthood-los-angeles
1316 3rd Street Promenade #201
Santa Monica, CA 90401
800.576.5544

RAINN (Rape, Abuse, & Incest National Network)
National Sexual Assault hotline
800.656.4673
https://hotline.rainn.org/online/