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Let's talk about sexuality: A sex-positive approach to clinical practice in Austria

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1. Introduction

Sexuality, sexual health and health problems

Sexuality is described as a core part of being human, encompassing sex, gender identity and roles, eroticism, pleasure, intimacy and reproduction (WHO, n.d.-a). Sexual health is important for overall health and well-being. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. The ability to achieve sexual health is dependent on access to sexual health care and knowledge, as well as living in an environment that promotes sexual health (WHO, n.d.-b). Issues related to sexual health are widespread, ranging from gender orientation and identity over relationships to sexual expression and pleasure.

The German health and sexuality survey (GeSID) from 2020 reported a prevalence of 45.7% in women and 33.4% in men for having one or more sexual problems. Sexual dysfunction which caused significant distress was reported by 17.5% of sexually active women and 13.3% of sexually active men (Briken et al., 2020). “Orgasmic dysfunction was approximately twice as common in women as delayed ejaculation was in men. The prevalence of erectile dysfunction increased with age, while that of early ejaculation decreased. Women felt particularly impaired by pain associated with sexual activity” (Briken et al., 2020, p. 653).

Sexuality impacts people across a lifespan and intersects profoundly with diversity factors due to the sexual stigmatization of marginalized identities (Mollen et al., 2020). This underlines the important role counseling psychologists play, while supporting clients with their mental health challenges.

Intersection of sexuality and mental illness

People with mental illnesses report difficulties in initiating or maintaining intimate relationships, as well as negotiating sexual safety regarding violence, transmission of diseases and exploitation (McCann et al., 2019). People with severe mental illnesses are more likely to experience sexual assault and sexual dysfunction, which makes sexual health services very important for this population (Brown et al., 2025). Moreover, romantic and sexual relationships can be key facilitators and indicators of recovery in persons with severe mental illnesses (Boucher et al., 2016).

Many pharmacological drugs have side effects which can directly or indirectly influence physical sexual function, as well as sexual expression and intimacy (Urry et al., 2019). Treatment-emergent sexual dysfunctions in people with severe mental disorders seem to be underrecognized and thus undertreated, leaving patients to care for themselves (Tennille et al., 2022). Antidepressants, antipsychotics and mood stabilizers with hormonal effects are often linked to moderate or severe sexual dysfunction, including decreased libido, delayed orgasm, anorgasmia, and sexual arousal difficulties (Montejo et al., 2018). Severe mental disorders can influence sexual function and satisfaction, even though patients would like to sustain their previous sex lives. A lack of intimate relationships and a decline in mental and physical health can be accompanied by either a poor sex life or more frequent sexual risk behavior compared to the general population (Montejo et al., 2018).

Even though sexuality is a fundamental part of being human and people with mental disorders are more likely to experience difficulty in their sexual lives (Brown et al., 2025; Urry et al., 2019), the discourse about it with mental health professionals is scarce (Anex et al., 2023; Love & Farber, 2017; Seitz et al., 2020). Talking about sexuality appears to be taboo – a so called 'two-way-taboo, as neither health care professionals, nor patients initiate conversations about sexual health. This leads to unmet needs and underestimation of issues regarding sexuality and sexual health (Nimbi et al., 2022; Traumer et al., 2019).

Difficulties talking about sexuality in mental health settings

Mental health providers report having problems talking about sexuality because of various reasons. Some of these challenges have been identified in a study by Urry et al. (2019): The anticipated embarrassment that comes with talking about sexuality and the belief that discomfort could be a potential threat to the therapeutic relationship was reported. Moreover, mental health professionals mentioned that the topic of sexuality does not come up naturally, and patients are responsible for bringing it up themselves. This belief disregards the socially reinforced shame and secrecy around sexuality. Studies have shown that if the counselor does not open up the space for conversation about sexuality and does not normalize the talk about uncomfortable topics, the clients are less likely to do so themselves (Brown et al., 2025). Furthermore, if there are no issues brought up, the common assumption is that there are no problems present (Urry et al., 2019).

Other challenges seem to be a narrow definition of what sexuality entails – reducing it only to the act of sex – and perceived differences between clinicians and clients (Urry et al., 2019). If the clinician differed significantly in terms of age, gender, perceived ethnicity and religious

belief, patients seemed more reluctant to talk about sexuality (Urry et al., 2019). Furthermore, prejudiced views of mental health professionals were brought forth: they assumed sexuality to be less relevant for elderly people and women (Urry et al., 2019).

Talking about sexuality in therapeutic settings is often deemed to be of little importance or useless. This notion acts as a means of straying away from the fact, that it might be an important part of people's lives and impacting their experiences of distress (McCann et al., 2019). Addressing symptoms of mental distress directly is seen as a priority and everything else will fall into place once this is achieved, thus making it not a priority in the therapeutic process. Some clinicians seem to think it is not part of their job to support people with their sexual challenges and seem quick to refer them to other professionals, who are 'better equipped' for the job (Urry et al., 2019). The responsibility of dealing with sexuality is placed outside of the mental health realm completely.

Personal values about sexuality can further influence how clinicians talk about sexuality. Not being educated enough on the various ways sexuality can be lived and expressed, counselors may result to their own normative concepts of how sexuality should be lived and expressed, resulting in pathologizing certain non-normative practices, such as kinks and other non-normative behavior (Brown et al., 2025). If there is no space provided to properly acknowledge and reflect one's own perceptions and beliefs about normalcy and sexuality, we run the risk of reproducing it unconsciously. Moreover, knowledge gaps or insecurities around certain topics lead to avoiding these topics altogether due to risk of 'embarrassing' oneself by showing 'incompetence' (Southall & Combes, 2022). Mental health professionals, including mental health nurses have reported a lack of knowledge when it comes to dealing with sexual challenges (Hendry et al., 2018; Urry et al., 2019).

Not having been taught how to talk about issues concerning sexuality, professionals might create "zones of silence" out of their own discomfort. This might result in leaning on implicit beliefs in their work, resulting in cognitive bias and other errors (Arczynski & Burnes, 2025). This in turn might further perpetuate the stigmatization of minority groups and marginalized sexualities. As mental health training programs reflect the socio-political context, the result is insufficient sex education for clinical professionals (Arczynski & Burnes, 2025).

Sexuality in a patriarchal society

The discourse and attitudes towards sexual health are deeply entangled with normative concepts of gender. Within cultures, gender belief systems are developed, which dictate the content of

gender stereotypes, the constitution of femininity and masculinity, as well as attitudes towards people, who deviate from these traditional set of roles (Valved et al., 2021). Norms guide behavior and shared definitions of normality create behavioral expectations, as well as sanctions for not adhering to these norms (Egan & Perry, 2001; Heyder et al., 2021).

In a patriarchal society, heteronormativity and cisgenderism are present norms. Heteronormativity describes the assumption that heterosexuality is the default (European Institute for Gender Equality, n.d.) Cisgenderism refers to the ideology that denies or pathologizes self-identified gender identities that do not align with their assigned gender at birth, as well as corresponding gender expectations (Berger & Ansara, 2021). The need for mental health professionals, especially clinical psychologists, to critically reflect on normative concepts of sexuality and sexual health is especially important when considering the classification changes, that will be implemented from ICD-10 (WHO, 2016) to ICD-11 (WHO, 2019). These changes signify a movement toward destigmatization of sexual concerns as well as being trans or gender-diverse (Arczynski & Burnes, 2025). It symbolizes an expansion of what we define as normal and appropriate sexuality and sexual behavior (Giami, 2015).

Transgender and gender diverse people experience pronounced health disparities, especially in contexts lacking legal gender recognition or protections of their rights (Lelutiu-Weinberger et al., 2025). They are at greater risk for several mental health disorders such as depression and PTSD, self-harming behaviors and suicidality compared to the cisgender population (Barr et al., 2022). One explanation for this can be found in the gender minority stress model for trans people, which has been validated cross-sectionally (McQuillan et al., 2021; Miller-Perusse et al., 2022). It predicts negative mental health outcomes for trans and gender diverse people due to gender-based marginalization they experience. This model describes distal stressors such as discrimination, rejection, invalidation and proximal stressors such as internalized transphobia, concealment and expected rejection (Barr et al., 2022). Moreover, studies have found that trans people are less likely to get appropriate care due to lack of knowledge and biases of physical and mental health professionals (Dziewanska-Stringer et al., 2019) and are likely to experience microaggressions in therapy (Morris et al., 2020).

Gendered norms are represented in the realm of sexual health in various forms such as communication discrepancies (Machette & Montgomery-Vestecka, 2023), sexual double standards (Quinn-Nilas & Kennett, 2018), dismissive attitudes of non-normative sexual behavior (Ludwig et al., 2023) and rape myths (Renken & Saucier, 2024). A deeper understanding of the underlying mechanisms can be provided by *sexual script theory*. Sexual script theory (Simon &

Gagnon, 1986, 2003) posits that people have sexual scripts, which are considered cognitive structures that guide individuals through various sexual contexts and interactions. Moreover, these scripts define which behaviors are considered appropriate. Simon and Gagnon (2003) posited the construction of sexual identity as an interactional process, that one *does* – meaning a fluid process contingent upon cultural context.

Even though there's evidence that these scripts have become more egalitarian, traditional heterosexual scripts regarding dating and sex remain (Quinn-Nilas & Kennett, 2018; Sahaluk et al., 2014). Men are expected to initiate and pay for dates. They are expected to lead, emotionally as well as physically and always be ready for sex. Men are made responsible for women's orgasms, and their performance becomes a key factor in satisfactory hetero sex, whereas women are seen as passive, in service of or to men's pleasure. In accordance with traditional gender roles women are seen as the "gatekeepers of sexuality," delaying sexual activity until emotional connection is established. Women's sexual scripts are always investigated in the context of men's scripts - establishing heteroattraction as the norm. Only minor deviations from these scripts seem to be acceptable, whereas major deviations are not (Sahaluk et al., 2014).

A dangerous way in which gender roles and norms can play out as well, is in form of sexual violence. One in eight women have experienced sexual violence, including rape, by a non-partner (*Every Third Woman in the EU Experienced Gender-Based Violence*, 2024). Survivors of sexual violence may experience short term as well as long term consequences, such as various mental health disparities and physical injuries (Stockman et al., 2025). Studies have shown that one's experience and expression of sexuality can be altered in many different ways after surviving sexual violence including sexual dissatisfaction, sexual dysfunction, changes in sexual frequency, and increased risk behavior (Stockman et al., 2025). As the realm of sexuality has been shifting to a more virtual one, sexual violence has taken on new forms. Non-consensual sharing of sexually explicit images is a very common problem, especially in younger generations (Rodgers et al., 2023; Symons et al., 2018).

Being up to date

As societal norms are changing, it is important as a clinician to be open-minded and mentally flexible. Some of these changes are: the removal of solo sex for women as a taboo, as well as women living their sexuality more freely in general, resulting in more casual sex than decades ago (Fahs & Munger, 2015; Kraus, 2017). Other changes appear to be in regards of how relationships are lived by challenging the monogamous ideal. In western societies, monogamous relationships are seen as the natural way of doing relationships. This belief system entails that

almost all people want to marry, and that loyalty and order are primarily established through romantic relationships (Sandbakken et al., 2022). Straying from this ideal can be seen as threatening to the 'natural' order of society, thus people living in polyamorous relationships risk being stigmatized, discriminated against and invalidated.

These consequences can in turn create internal stress and turmoil resulting in mental and physical health challenges (Sandbakken et al., 2022). Mental health care professionals do not have sufficient knowledge about polyamory, how to navigate those dynamics and have not challenged their personal opinions and assumptions on that matter enough (Kisler & Lock, 2019). As a result, poly patients experience stigmatization and discrimination against their relational orientation, with some professionals only associating their relational orientation as the cause of interpersonal distress (Grunt-Mejer & Lys, 2022).

Due to the digitalization of the world, sexuality as well has become part of the virtual world i.e. sexting, pornography. These changes, as well as the problems of making sexual health talk a taboo, the focus on dysfunction, prejudices and biases concerning sexuality need to be studied and addressed accordingly (Anex et al., 2023; Nimbi et al., 2022). This might prevent harmful norms from being reproduced and reduce the barriers to talking about sexual health. But how can this be achieved?

Sexpositivity as a possible solution

One solution would be to approach sexuality in clinical settings with sexpositivity. Sexpositivity in general promotes the importance of open mindedness with respect to sexual and gender expressions, a nonjudgmental attitude and respect for personal autonomy, centering consent for any sexual behavior, discussing different sexual expressions and behaviors as well as emphasizing the validity of a person's sexuality and focusing on psychoeducation (Nimbi et al., 2022). It entails critically reflecting on traditional understanding of erotic practices subject to heterosexism and monogamy-normative prejudices, as well as socio-cultural factors influencing people's expressions and experiences (Arczynski & Burnes, 2025; Nimbi et al., 2022). It means critically reflecting on prevalent societal structures, their uneven impact on different groups of people and the injustices this might create. With this approach to clinical practice, it is possible to recognize and work on the effects of social inequities, stigma, minority distress and individual attitudes and beliefs, for clients as well as for clinicians (Arczynski & Burnes, 2025).

Cruz et al. (2017) postulated a few ways in which a sex-positive approach to sexuality can be implemented in everyday clinical practice. Personal beliefs and attitudes towards sexuality need

to be examined and critically reflected, as well as a certain level of comfort in talking about sexuality needs to be established. Moreover, the topic of sex and sexuality needs to be proactively raised in therapeutic settings. Having knowledge about the limits of broaching sexuality is important, as well as recognizing the nuances in talking about it and relying on clinical judgement (Cruz et al., 2017).

Critical practice and critical inquiry are of great importance (Arczynski & Burnes, 2025). Clinical psychologists need to understand the meaning and consequences of multiple systems of oppression co-occurring at the same time. These systems create unique forms of systematic injustices, thus shaping people's experiences (Arczynski & Burnes, 2025). This is especially important considering other discrimination forms intertwining with one another (Hill et al., 2025), resulting in inaccessible sexual healthcare and discrimination (Hargons et al., 2017). Tennille et al. (2022) further report, that establishing comfort in talking about sexuality needs additional support such as professional guidelines and tangible resources, as well as practical training exercises.

The research in German speaking countries about how sexuality is talked about in clinical settings is sparse. There are only a few studies regarding clinical professionals and how they try to navigate the intersection of sexuality and mental health issues in clinical settings. Furthermore, there are not many qualitative studies where researchers tried to provide a deeper understanding about the taboo of talking about sexuality in clinical settings, as well as the specific barriers and providing possible solutions. With this study, I try to bridge this gap.

Thus, I asked the following research questions (RQ):

1) What are the reasons for people not talking about sexuality in clinical psychological settings? What are communication barriers and facilitators in that regard?
2) How is a professional attitude towards sexuality defined?
3) What have clinical psychologists learned about sexuality during their training in Austria? Did they perceive a change in professional standards and what role has the reflection of societal norms played?

2. Methods

This study uses qualitative methods, as the aim of this study is to provide a deeper understanding of how sexuality is talked about in clinical settings, as well es communication barriers and facilitators, the sex education of mental health professionals in Austria and what a professional attitude towards sexuality is. Therefore, I approached this study from a constructionist perspective, by examining the ways in which the realities, meanings, experiences etc. of participants are the effects of a range of discourses operating within society (Braun & Clarke, 2006). Informed signed consent was obtained from participants.

2.1. Procedure

This study consists of semi-structured interviews. The interviews were conducted in person and virtually via Zoom. Interviews lasted 57 to 86 minutes, with an average of 73 minutes (see Table 1). Questions included the conversations about sexuality they were having in their professional day-to-day life, communication barriers, what they have learned during their training in Austria, the reflection of norms and their definition of a professional attitude towards sexuality. The aim was to obtain contextually rich data about how participants feel about talking about sexuality, the possible barriers and challenges, sex education of mental health professionals in Austria and what their definition of a professional attitude towards sexuality is.

Table 1

Sociodemographic characteristics of participants and interview characteristics.

Variable	Category	Frequency (N=8)	Mean	SD	Min	Max
Age (years)			43,6	7,30826342	30	53
Gender	Men	1				
	women	7				
Graduation (year)				7,36788398	2023	1999
Interview duration (min.)			73,25	8,61		
Interview type	In person	6				
	Online	2				
Interview language	German	8				

Note. Graduation (year) = The year participants completed their postgraduate training.

2.2. Setting

Interviews were conducted from July 2025 to October 2025 in Vienna. All the in-person interviews were conducted at the participants' workplaces. The online interviews were conducted via Zoom. All the interviews were done in German and recorded with my smartphone.

2.3. Sample and recruitment

The sample consisted of eight clinical psychologists currently working in Austria, aged between 30 and 53 (see Table 2). This study focuses on the context of the Austrian higher educational system. which is why only clinicians who have finished their postgraduate training in Austria were included.

Participants were recruited via email. I searched for potential participants on various websites such as www.psychologen.at, https://klinischepsychologie.ehealth.gv.at/, https://www.psychnet.at/, as well as psychologists own websites. Some of the interviewees referred me to some of their colleagues. There were no strict sample size requirements, but I set a maximum number of eight participants to keep the analysis in a realistic time frame. The objective of the recruitment strategy was to maximize heterogeneity. Thus, clinical psychologists from various fields of psychology were recruited – some with a work focus on sexuality and some without. Furthermore, clinicians were included who completed their postgraduate training decades ago as well as clinicians who were newer to the work field.

Table 2

Comprehensive overview of socio-demographic characteristics of participants.

Age (years)	Gender	Ethnicity	Religion	Work country	Graduation (year)	Focus	Code
53	w	white	none	AUT	1999	Sexuality & Psychooncology	P1
47	m	white	none	AUT	2015	Sexuality & Trauma	P2
48	w	white	none	AUT	2005	Psychooncology	P3
30	w	white	none	AUT	2023	Sexuality	P4
44	w	white	none	AUT	2010	Chronic illnesses	P5
44	w	white	none	AUT	2013	Sexuality & Corporate	P6
36	w	white	none	AUT	2017	Clinical Psychology	P7
47	w	white	none	AUT	2010	Sexuality	P8

Note. W = Woman; M = Man; Work country = Country they are currently working in; Focus = Areas, in which participants have expertise in and mainly work in; Code = Codename for each participant.

2.4. Materials

The semi-structured interview guide included three main topics: talking about sexuality in clinical psychological settings, sex education of clinicians in Austria and how they define a professional attitude towards sexuality. Each topic included various conversational stimuli based on my research questions such as "When you think about your typical workday – How much would you say do you talk about sexuality?", "What are the most common topics?", "Who initiates the conversations most of the time?". The interview guide is in German as this is the everyday language of all the participants. At the bottom of the interview guide, there is additional information regarding sexpositivity. This was only used if participants said that they did not know what sexpositivity exactly is and/or wanted a definition of it. At the end of every interview, a short demographic questionnaire was administered.

2.5. Reflexivity and establishing trustworthiness

I am a cisgender woman, with an academic background – like most of the participants. The similarities between me, the interviewer, and the participants might have influenced how comfortable the participants felt talking about their work experiences and their opinions on certain topics, such as gender roles and patriarchal structures. Moreover, my personal positioning as an intersectional feminist might have impacted the way the interviews were conducted, the generation of the themes, as well as how at ease the participants felt sharing their opinions on topics such as trans people and patriarchy. As an intersectional feminist, I reflected thoroughly on my own personal stance on the discussion about trans people. I consciously decided to not reproduce some of the language that was used in the interviews as it could possibly cause harm. In reflexive Thematic Analysis (TA) researchers' subjectivity is seen as an analytic resource rather than a problem, which needs to be controlled (Braun & Clarke, 2021). This method encourages its' researchers to critically reflect on one's own assumptions and how they might shape and limit the coding process. In the present study, I reflected thoroughly about the data during the whole process in line with what Braun and Clarke proposed (2021) as *six phases of a reflexive approach*: familiarization with the data; coding; generating themes; reviewing and developing themes; refining, defining and naming themes; and writing up.

2.6. Analysis

Data were analyzed using an inductive, reflexive TA approach (Braun & Clarke, 2021). TA, as a qualitative research method, identifies and reports patterns (themes) within a dataset. Main themes, which answer the research questions were generated. I chose to use TA to have an in-

depth look at how sexuality is talked about, the barriers of talking about it and the influence of societal structures on the discussion and reception of the topic. TA is a great match for the research questions I ask, because I wanted to examine participants subjective experiences and their sense-making of it (Braun & Clarke, 2021). All audio-recorded material was transcribed in German. I conducted all the interviews and analyzed them myself, thus I familiarized myself with the data thoroughly. The complete dataset was coded, using the qualitative analytical software MAXQDA (VERBI-Software, 2021). The transcripts remained in their original language, but codes were phrased in English. I used open coding and coded only the segments of data that I thought were relevant to my research questions. Codes are the most basic unit of meaningful data (Clarke & Braun, 2021). Then, codes were organized into subthemes and themes. This consisted of comparing codes across participants and identifying patterns that were common across many participants or unique to some. In my approach, themes represent a metalevel of analysis as they are united by a central concept or idea, whereas subthemes are one analytical level below them –they are part of the themes, grouping numerous codes together as they only represent a shared topic (Braun & Clarke, 2021). Initial themes were developed by using sticky notes and creating collages similar to mind maps. Then these initial themes were reviewed and refined by regrouping them. Finally, the themes were organized in a way that answered the three RQs.

3. Results

RQ 1 is answered by the themes "Sexuality: Multifaceted and culturally taboo" (1) and "Talking about sexuality with mental health professionals" (2). RQ 2 is answered by the theme "Professionally talking about sexuality" (3). RQ 3 is mainly answered by the theme "Heterogeneity of psychological training" (4). Some of the research questions can be answered by multiple themes, which will be discussed later.

Theme 1 – Sexuality: Multifaceted and culturally taboo

Religion, patriarchy and cultural norms: The trifecta of sexual taboo

Participants theorized how and why sexuality was made a taboo. They mentioned childhood and learning from caregivers as a main source of cultural socialization. How adults talk about their bodies, how comfortable they are with showing their bodies and how they react to nakedness of children seem to be powerful social learning mechanisms:

> *Yeah, (um) because I think it has a lot to do with family upbringing, (um) (um) like the way people communicate at home, whether I'm allowed to talk about my private parts at home, (um) how do I get dressed at home? Or is everyone self-conscious about it? Have I ever seen my parents naked? (Um) What do I know about that? (Um) What's it like in preschool? I mean, how is that handled there? (Um) I mean, how are there just external judgments about one's own genitals? (Um) How are bodies perceived—what are the different body types? (P7)*[1]

Moreover, participants mentioned that from a young age children are exposed to traditional gender roles, as mostly mothers stay at home with their children and are responsible for most of the care work. Children learn from a young age what it means to act accordingly to gender role expectations and the pressure and scrutiny that comes with defying those (Egan & Perry, 2001; Heyder et al., 2021). It was stated that these gendered norms are not inherently bad, because they are necessary guidelines for all humans, yet strictly following them without leaving room for questioning can be seen as restrictive. It was mentioned that gender norms can be helpful guidelines for trans people but can also put pressure on them as the need to strictly adhere to them to be the 'perfect woman or man' can arise.

[1] Original quotation in the appendix

Another powerful driving force, which was mentioned, was religion. Not one specific type of religion, but all of them collectively. Even though participants mentioned that the church is not as influential as it used to be, it was mentioned that the older generations were deeply influenced by it, and they now pass down the shame that came along with it. It was mentioned that western culture is deeply entangled with religious moral judgments, as well as that sexuality and the naked human body have been demonized for decades.

As we live in a digital age, social media also influences how we deal with and talk about sexuality. On the one hand, certain types of explicit content are easily accessible for everyone including teens and children, yet social media platforms such as Tiktok, Instagram and other platforms censor sexual content very rapidly. Posts regarding nudity, mostly women's bodies, or people mentioning sex or sexuality, even for educational purposes, will be deleted or even banned. This ambiguity creates a certain confusion around sexuality and fuels the taboo further. Moreover, it was mentioned that social media informs people on body ideals and expectations, sets relationship expectations and fuels comparison between people.

Sexuality between avoidance, discrimination and knowledge gaps

Participants described that the general discourse about sexuality is informed by shame and reactance to talk about it. Clients seem uncomfortable and at a loss for words describing how they feel and what they would like to share. These inhibitions concerning the discourse about sexuality were described as deeply entangled with societal norms and morals:

> *Well, whenever it comes to inhibitions, you know, of course—like, what's normal, what's right, what's proper, you know, what exactly counts as normal sexuality—concepts of arousal can vary a lot, or what someone finds arousing, you know, and there are just some things that society might be more (um) accepting of than others, you know. So, what you learn is what's okay or not okay, you know...(P8)*[2]

The discourse about it was described as circulating around gendered norms and role expectations i.e. sexual double standards and traditional gender roles. Double standards were described as men are celebrated for having multiple sexual partners and openly voicing their desires, whereas women were scrutinized for it. Women were described as overly compliant and always catering to the needs of others instead of their own, whereas men seemed to be mostly concerned

[2] Original quotation in appendix

with being 'man enough' and performing as such. These ideas concur with sexual scripts posited by Simon and Gagnon (2003):

> *What do I actually want, and what's too much for me? I often find myself doing things just because I think that's how it's supposed to be. With women, I often hear that men like it that way, that it makes them HAPPY. Men have this issue too, right? That I have to PERFORM and deliver, and only when the woman has an orgasm is it considered a success. (P8)*[3]

Women in particular were described as being riddled with shame around sexuality, due to the century long censorship of their bodies, voices and thus their sexuality. Moreover, the way in which sexual assault survivors in western media and society are being treated, was mentioned as another contributing factor in silencing women.

Participants stated that sexuality is often defined heteronormatively by the general public, i.e. people are expected to be heterosexual, act according to their gender roles and perform sex in a heterosexual way. Sexuality as a general concept is often reduced to normative behavior and expressions, without questioning one's own identity and desires. It was mentioned that people who defy certain norms seem to reflect more about their various parts of identity and how they have been influenced by societal structures, than people who are, by default, norm conforming (cisgender and hetero).

Sexuality: Building identity, relationships and society

Overall, participants describe sexuality as a vital part of being human concerning everyone. It was mentioned that it might not be an important topic for all people, but it is a topic that affects everyone, regardless of age, gender, ethnicity, mental or physical health status. Participants stated that sexuality is an important part of many types of relationships, as well as the relationship to oneself and one's body: "*I think it's also hard to cover everything, but of course, sexuality is something everyone has. So every person has some kind of sexuality—even if it's asexuality, that's still a form of sexuality—and that was actually a topic that came up very rarely. "*(P4)[4]

Interviewees mentioned that sexuality can be a valuable resource in healing processes. Fulfilling sexual experiences can be a great way to connect with oneself and loved ones again and can be some sort of reclamation of one's body after becoming object to multiple medicinal

[3] Original quotation in appendix
[4] Original quotation in appendix

operations. Diseases in general were described as an influential factor on sexuality and the relationship to oneself and others. Furthermore, it was reported that a changed sexuality can be seen as a symptom of disorder.

Sexuality was described as a lifelong learning process, constantly rejuvenating itself as one gets to know oneself better: "*Or, well, yes, so learning processes, yes. (..) So, sexuality is learned, (um) and it's also a lifelong learning process, just like everything else."* (P6)[5]

Moreover, participants stated that sexuality is political. How sexuality is lived and expressed, and by whom can be influenced by the current political situation that a country is in, i.e. legislation, current social movements.

Theme 2 – Talking about sexuality with mental health professionals is dependent upon clients, psychologists, their relationship and professional knowledge

Social similarity and sexual transparency

Participants reported that talking about sexuality seems to be easier the more similar client and psychologist are to each other. There seem to be specific challenges when it comes to oppositional gender settings, where life realities seem to be farther apart, which in turn makes it harder to relate. Nonetheless, some psychologists see oppositional gender settings as a specific opportunity for healing to take place and correcting year long beliefs and assumptions.

Challenges in talking about sexuality were reported. One of them was ethnicity. It was reported that clients, who are thought to be of a certain ethnic background, will be asked more carefully or differently about sexuality. Moreover, generational differences were reported as another specific challenge, as there is this common stereotype in society that sexuality is not important to older people anymore or that it cannot be directly addressed. In comparison, it was mentioned that younger people will easily be asked about their sex life:

> *(..) This is just a thought of mine, because I don't know for sure, but I think it probably resonates more with younger (um) patients because of the prejudice that it's less important as you get older, or because of the PARTIAL prejudice that it's less important as you get older. (.) I think that, on average, older people are more likely to say, for example, that*

[5] Original quotation in appendix

sexuality isn't as important to them as it used to be, which of course doesn't mean it isn't important. (P3)[6]

Another challenge that was mentioned was gender differences. Men were described as tending to look for quick fixes for their problems and seem dissatisfied with time consuming solutions in comparison to women. Furthermore, men, in some instances, pose to be a threat in clinical settings where sexuality is discussed, especially if the clinician is a woman. Participants described moments of men crossing boundaries and exhibiting inappropriate behavior and advances, forcing them to reiterate their professional work boundaries multiple times. Being on the older side of age was reported to be a protective factor in these cases.

Opening up about sexuality is described as difficult due to the very taboo nature of it and the shame that comes with talking about it or appearing as 'not normal.' Some clients appear to be more ready to talk about it due to their own open nature or the importance that they place on sexuality matters, as well as the openness of the clinician. Participants reported clients tend to bring up sexuality matters more often, when they are aware that they are allowed to, i.e. when psychologists state their sexuality work focus on their website.

From classic problems to questioning everything: Changing trends in expression and openness of sexuality

The classics of sexuality, which were mentioned, were libido differences, libido loss, performance pressure and body issues over all genders:

The top 3 for men are erectile dysfunction, premature ejaculation, and, well, number 3. (.) (Ah) It's not entirely clear, I'd say (laughs). (Um) For women, it's actually orgasm, time and again. (.) But also a lack of desire. Actually, I have the top two for each gender (laughs). And everything else is a bit of a variation on that, or—there are also rarer issues, (ahm) (.) where all sorts of things come up (laughs). (P6)[7]

In addition to that, a lot of women brought forth pain during intercourse and experiences of sexual violence*: "Unfortunately, the biggest issue when it comes to sexuality is that (um) I have a lot of female clients who have experienced sexual abuse as children or sexual abuse in their relationships. "(*P5)*.*[8]

[6] Original quotation in appendix
[7] Original quotation in appendix
[8] Original quotation in appendix

Some topics that were reported to be emerging now are alternative relationship models i.e., poly relationships and their specific challenges. Gender differences regarding poly relationships were reported. Men stated more often that they wanted to be in poly relationships or to open the relationships than women. Participants described questioning one's gender identity and orientation as another emerging topic, especially during teenage years and young adulthood. Younger people were reported to be concerned about their identity, as well as first experiences regarding sexuality and communicating with caretakers about their journey.

The discourse trends are contingent upon current political climates in the residing country, as these are connected to regulations of certain minority groups such as trans people. Participants described an overall change in living and expressing sexuality in the younger generation compared to the older one, as they seem to be more liberal and open.

Theme 3 – Professionally talking about sexuality: Reflect, seek feedback or cause harm

Signaling openness while maintaining boundaries

A professional attitude towards sexuality was reported to be a balance between maintaining one's own boundaries as well as respecting boundaries of clients. Moreover, knowing one's own professional boundaries and limits was mentioned as a fundamental part of a professional attitude. Signaling openness and curiosity, as well as a non-judgmental attitude were listed as important as well. Respecting clients' experiences and validating them was described as another important facet. Participants stated that having awareness around the fact that sexuality is a taboo topic, as well as enough knowledge is important.

It was reported that language is another important factor. Using appropriate words to talk about sexuality means talking about it in a way that maintains professional boundaries but also does not sound too medicinal and unnatural. Psychologists need to be comfortable with the language they are using for clients to do the same: "*I think language a loooot of it is language. So how do I phrase things? It's not that simple, because it's actually a bit of a balancing act, I think— you can also adapt a little to the person you're talking to."* (P4)[9]

Participants described the relationship between mental health professionals and clients as of high importance, thus awareness for the dynamics that can emerge and skills to navigate them are necessary. Due to the very nature of the therapeutic relationship, it can happen that clients develop romantic feelings for or feel attracted to clinicians as well as the other way around.

[9] Original quotation in appendix

Being aware of and knowing how to navigate delicate feelings, while maintaining professional boundaries was described as necessary but difficult, even more so because it seems to be a taboo to talk about amongst colleagues.

It was mentioned that psychologists need to reflect about their own sexuality, what they have learned and the taboos they grew up with. Psychologists are expected to have dealt with their personal issues to not project them onto clients and the same is expected when it comes to sexuality. If this important introspective step has not happened, harmful dynamics and situations are bound to happen. Making use of opportunities such as intervision, supervision and self-experience are reported to be excellent spaces to reflect with others:

> *But if there are any personal issues, which is generally the case, then as a psychologist you have a bit of an ethical obligation to work through them all. You don't have to project it onto clients. Yes. That applies particularly to the area of sexuality, I would say. (P6)*[10]

Sexpositivity: Useful tool or trend?

Participants described sexpositivity as a positive attitude towards sexuality in general. Respecting and validating people's expressions of sexual orientation, gender and sexual practices, respecting autonomy, as well as centralizing consent. Furthermore, psychoeducation and sexual health education were mentioned as being part of sexpositivity. Participants definition of sexposivitivity overlaps to a great degree with their definition of a professional attitude towards sexuality, as well as a sex positive approach postulated by Nimbi et al. (2022). Some participants even think of sexpositivity as a modern and necessary approach to working with and talking about sexuality:

> *This is allowed and that isn't. (imitating) I mean, that's such a rigid notion of sexuality and relationships—how they should be lived and what's "right"—as advocated primarily by conservative circles, whereas sex positivity simply represents a more liberal, needs-oriented approach to sexuality, right? And being needs-oriented really means doing justice to each individual—it's not just another (.) where Scheme A is the old way and Scheme B is the new way, but rather something that's always up for negotiation... (P2)*[11]

Some interviewees criticized the word 'sexpositivity'. They would prefer a more neutral term. The word "sexopenness" was recommended to make it more inclusive and better represent people, who deem sexuality as not an important part of their life, thus frame it less positively and

[10] Original quotation in appendix
[11] Original quotation in appendix

more neutrally. Another criticism was that the attitude does not necessarily reflect what is being practiced. Some mentioned that they see sexpositivity as a trend of the younger generation, where sexpositive spaces are used to party and take substances, misusing the original purpose of the movement and attitude.

Theme 4 – Heterogeneity of psychological training: Diverging opinions and lack of knowledge

Necessary knowledge and required self-reflection

Psychologists described some basics that every professional working with people should know about. The most basic principle which was mentioned was that sexuality is a topic for everyone – not important to all, but a topic concerning everyone. Moreover, it is important to know that there are multiple ways of living and expressing sexuality – and there is no right way. There are various gender expressions as well as sexual orientations. Knowing a few and knowing about the specific challenges and struggles these people experience was described as fundamental knowledge:

> *(Ahm) Well, I didn't have any (um) seminars during my training where the focus was really on (um) sexuality. So, I ended up attending (um) events or continuing education courses on the topic of (um) L… I… L.B.T.I.Q.+, yes, (um) on my own. Just to educate myself further, not because that's my area of focus, but simply to know something about it, because I don't know who will come to me for a diagnostic evaluation, and what—what will be there if I have absolutely no idea what needs they bring with them.. (P7)*[12]

Some other basic knowledge reported by the participants included: Having a certain level of body awareness as a necessity to connect to oneself and others as well as being able to communicate one's needs. Being able to have conversations about sexual needs, desires, discrepancies etc. was mentioned as another important facet. Participants wish for people to define sex less in a heteronormative way, seeing only penetrative sex as 'real sex' and to see it more broadly, where interpersonal dynamics and sensual play also are part of it.

Participants reported that they would like to know more about poly relationships, as they seem to be more relevant. Moreover, everything regarding queer people and especially trans people seems to be an area, where clinicians feel they have insufficient knowledge about and where they would like to educate themselves on.

[12] Original quotation in appendix

Available but hard to access: Barriers and future improvements for further training of clinicians

Opinions of participants regarding sex education of clinical psychologists is very different. The only thing participants agreed on is that sex education is too sparse in mandatory training in Austria and should be a bigger part of it, i.e. at university or in postgraduate programs. When it comes to further training possibilities opinions are split. Some clinicians stated that there are enough further training possibilities, some say there aren't enough. Of those who stated there are enough possibilities, they also stated that they mostly do not take up the offers due to budget reasons or not having enough time.

Some participants claimed that there is enough learning material outside of the scientific psychological community and educational institutions, which is why they prefer to educate themselves on their own. Nonetheless, there seems to be a struggle in identifying high quality from pseudo-scientific material. Postgraduate study appears to have become more of a solo journey than a joint adventure.

Wishes for the future included: making sexuality a more important part in education of clinicians in Austria, using more sensitive language, not exempting children and teens from the discourse about sexuality, dealing with one's own biases regarding sexuality and getting tools for how to deal with taboos and shame: "*So actually, it would be desirable to have more lectures on the subject, nh. Yes, actually, it belongs in the university discourse, so not at all, it's something like that, something like that, if we look at basic needs..*" (P2)[13]

Ridicule and respect: Professional norms around the role of sexuality in the clinical psychology community

Participants reported diverging opinions on when to talk about sexuality in clinical settings. Some stated that sexuality should be assessed everywhere, including diagnostics, whereas some voiced the opinion that it is best to assess is, only when necessary and with a stable enough relationship. It was stated that it is necessary to carefully consider priorities i.e. acute crisis and specific wishes of clients when talking about sexuality:

> *It always depends on the purpose of the diagnosis, of course, but generally speaking, yes. So if you're asking whether the topic is underrepresented in existing tools as well, yes, I think so. (.) And (um) for me, it's always a bit of a balancing act—it's an exaggeration,*

[13] Original quotation in appendix

but you just have to find a middle ground: on the one hand, respecting the fact that it's a taboo topic and dealing with that, and on the other hand, breaking the taboo to some extent. (P3)[14]

The importance of sexuality in the general psychology community was described as ambiguous – there seems to be a general awareness to it, yet also an avoidance of it. Missing guidelines concerning professional statements to gender dysphoria and missing consensus on what is normal were criticized.

Amongst colleagues, different topics of conflict were reported. Gender fair language was mentioned as one of them. Furthermore, some psychologists seem to have problems with calling clients the correct pronouns. Another topic which was described was the personal opinion of clinicians regarding queer and trans people. A general insecurity due to lack of knowledge and exposure to working with these groups was reported: "*Yes, when heterosexuality is simply ASSUMED, but a female patient is married to a woman, and the entire clinic staff doesn't know how to handle the situation."* (P1)[15]

Because of the great ambiguity and diverging opinions that reside in this community, a greater need for connectedness between professionals was described. Knowing who to refer to, if one's own knowledge is not enough or when one's own capacities have reached their limit, as well as educating oneself were described as important.

[14] Original quotation in appendix
[15] Original quotation in appendix

4. Discussion

The aim of this study was to provide a deeper understanding of the discourse about sexuality in clinical psychological practice, as well as sex education of mental health professionals in Austria and their definition of a professional attitude towards sexuality. While previous research on the discourse about sexuality in clinical settings has been sparse in general, with a few studies from English speaking countries, I tried to extend this body of literature to a German speaking country. Through my analysis I developed four themes: (1) Sexuality: Multifaceted and culturally taboo, (2) Talking about sexuality with mental health professionals is dependent upon clients, psychologists, their relationship and professional knowledge, (3) Professionally talking about sexuality: Reflect, seek feedback or cause harm, (4) Heterogeneity of psychological training: Diverging opinions and lack of knowledge.

The present study supports the findings of Anex et al. (2023) that the talk about sexuality with mental health professionals is sparse, characterized by societal norms and riddled with challenges. This study highlights the insufficient sex education of clinical professionals in Austria and the insecurities and biases as a result. Furthermore, it supports the proposition of Nimbi et al. (2022) to implement a sex positive approach to clinical practice. As Nimbi et al. (2022) and Arczynski and Burnes (2025) proposed, looking at sexuality through critical reflective practices of societal structures and how they shape expressions and lived experiences of sexuality are of importance.

The discourse about sexuality: In between societal and professional norms

My findings indicate that the discourse about sexuality in clinical psychological settings is dictated by societal, as well as professional norms. Influences such as culture i.e. familial socialization, as well as religion and gender norms were mentioned as powerful sources of information – for clients as well as clinicians. Moreover, not only societal norms influence how and if sexuality is talked about, but also professional norms. In accordance with the study of Urry et al. (2019), participants mentioned mental distress as a priority, insufficient professional knowledge and personal biases, thus making sexuality a challenging or sometimes less important topic to talk about compared to addressing mental disorder symptoms in clinical/therapeutic settings.

Because there are no clear guidelines on how and when to address sexuality in the process, participants' opinions on this topic diverged leading to different amounts of support regarding sexuality issues.

Sexuality was seen as part of being human – not important to all, but a topic concerning everyone. It was framed as an essential part of relationships, as well as a powerful resource in the process of convalescence. Moreover, it was mentioned as a political topic, as it is influenced by the socio-political context a state is in.

Participants stated that due to the taboo nature of sexuality and the shame that comes with talking about it, it is difficult to bring up in clinical settings, especially for clients. Having a reductionist view on sexuality as a whole concept was mentioned as another barrier for facilitating conversations about it. Furthermore, gender differences in talking about it were reported. In line with traditional gender roles and expectations, men and women reported different issues and concerns. Whereas men wanted quick fixes for their problems and were concerned about their performances, women were reported to be overly concerned for others, as well as for their safety.

Sexual problems, which were reported were in line with the German health and sexuality survey (GeSID) from 2020 (Briken et al., 2020). The classics consisted of libido differences, libido loss, performance pressure and body issues over all genders. In addition to that, it was described that women reported pain during intercourse and experiences of sexual violence as common issues. It needs to be mentioned that these common issues are primarily reported by cis-hetero people, including the findings of the study of Briken et al. (2020), providing no specific data on common issues of trans and gender diverse people.

Talking about sexuality in clinical settings was described as easier, the more similar client and clinician are to each other in terms of perceived gender, ethnicity, and age. Moreover, the openness and willingness to talk about sexuality, as well as the professional knowledge regarding the topic were mentioned as important facilitators of conversation, as it was also concluded in the study of Tenille et al. (2022).

A professional attitude towards sexuality: A balance of boundaries, taboo and sexpositivity

Participants reported a professional attitude towards sexuality as a balance between one's own professional and personal boundaries, as well as their clients.' Other key aspects which were mentioned were awareness of dynamics, taboos and shame, as well as openness, curiosity and a non-judgmental attitude. Moreover, critically reflecting one's own assumptions and biases about sexuality and norms were mentioned as important, which is further supported by research of Cruz et al. (2017).

Language was mentioned as part of a professional attitude. It is important to use language, which seems natural and comfortable to the speaker, making it less medicinal and distant, yet distant enough to maintain professional boundaries. Furthermore, adopting gender sensitive language to include and facilitate complex conversations about sexuality and gender was discussed as being important.

A sex positive approach to clinical practice like Nimbi et al. (2022) proposed, was assessed as useful and necessary to have professional conversations about sexuality. Participants' definitions of a professional attitude towards sexuality aligned to a great degree with their definitions of sexpositivity. Nonetheless, some participants criticized sexpositivity. They suggested a different name for the attitude, such as 'sexopenness' to frame it more neutrally, making it less positive and more inclusive to people who deem sexuality as not important. Furthermore, some participants raised their concerns about the legitimacy of the implementation of the attitude and mentioned that sexpositivity is more of a trend in the younger generation.

A sex positive approach to talking about sexuality in clinical settings can only be implemented fully if it pays attention to socio-political context (Arczynski & Burnes, 2025; Nimbi et al., 2022). Critical inquiry and reflection of how different systems of oppression and injustice shape conversations and experiences of the world and of sexuality need to be discussed. As participants mentioned that mental health professionals have a lot of insecurities around working with queer people, especially trans and gender diverse people, as well as different ways of dealing with conversations of sexuality with women, children and BIPOCs – these issues need to be addressed accordingly.

Heterogeneity of training clinical psychologists: Diverging opinions, conflict and insecurities

Participants reported that knowledge about the variety of sexual and gender expressions, roles, expectations, practices and general body awareness are necessary basics for all professionals working with people. Certain knowledge gaps were reported, particularly concerning queer, trans and gender diverse people, as well as alternative relationship models i.e. poly relationships (Dziewanska-Stringer et al., 2019; Grunt-Mejer & Lys, 2022; Kisler & Lock, 2019).

When asked about postgraduate training possibilities in Austria, the opinions were mixed. Some participants deemed them sufficient, even though many participants reported they were not making use of them due to time and budget reasons. Other participants stated there were not enough training possibilities, or they were of low quality.

Due to the heterogeneity of training possibilities and the lack of guidelines when it comes to sexuality, several topics of conflict among the psychological community were mentioned. One being gender fair language. Participants reported colleagues having problems with using gender sensitive language and using correct pronouns for clients. Moreover, the personal opinions of some professionals were reported to reflect their professional attitudes towards trans people, resulting in biases, stigmatization, undertreatment and a general insecurity of working with trans and gender diverse people. These findings further support the body of research about the insecurities and stigmatization of working with trans people in mental health care settings (Dziewanska-Stringer et al., 2019; Morris et al., 2020).

4.1. Limitations and future research

The sample of this study was a homogenous group. Participants were very similar to each other in terms of age, gender, ethnicity, educational background. For future research, it is recommended to recruit participants of a wider age range, as generational differences were mentioned to have an influence. Moreover, recruiting more men is recommended, because participants mentioned gender differences and their impact on the discourse about sexuality several times.

It is important to mention that all the participants talk about sexuality to certain extents with their clients already, more than half mentioning sexuality as a topic they mainly work with. Thus, it is recommended to recruit participants with more diverse work focuses. Furthermore, recruiting clinicians who deem sexuality to be an inappropriate or unnecessary topic to talk about in clinical settings would be recommended to gather more diverse opinions on the matter.

This study focused on providing information about clinical psychologists in Austria and their opinions on, views about and attitudes towards sexuality in clinical settings. This in turn disregards clients' perspectives on it. Future research should also focus on clients' opinions on the discourse about sexuality – their perceived challenges, facilitating factors, influences and attitudes towards sexuality. Going a step further, I would recommend comparing clients and their clinicians' statements to one another for a deeper understanding of the complex interactions that are at play.

With this study I propose a sex positive approach as a possible improvement of working with sexuality in professional contexts. In the interviews conducted, many intersections such as ethnicity, disability and minors were not or only shortly talked about due to economic reasons and reducing complexity. I recommend further studies to specifically gather more information on various intersections to better depict the complexity of it.

4.2. Implications

These findings suggest multiple practical implications for the future. Sexuality and sexual health need to be better integrated in mandatory training of clinical psychologists. A specific focus should be on different ways sexuality can be lived and expressed in forms of identity, attraction, relationships and specific practices. The lack of knowledge and insecurities about dealing with marginalized groups needs to be addressed and proper learning opportunities need to be made accessible (Nimbi et al., 2022).

One possible way to do so is to better equip supervisors in order to better train psychologists for talking about sexuality with their clients (Arczynski & Burnes, 2025). Supervision is a great opportunity for clinicians to reflect on their own beliefs and how they might impact their clients and their relationships with them. Furthermore, supervisors can adopt a sex-positive approach by approaching sexuality holistically and by exploring how sexuality and sex are constrained by social and cultural factors (Arczynski & Burnes, 2025; Nimbi et al., 2022).

The results of this study suggest a sex positive approach to clinical practice as useful and as necessary to deal with sexuality in clinical settings. Specific steps for implementation recommended by participants, as well as Cruz et al. (2017) are: Examining and critically reflecting one's own personal beliefs and attitudes towards sexuality, as well as establishing a sex-positive attitude and comfort in talking about sexual matters, proactively raising the topic of sex and sexuality during therapeutic sessions, knowing the limits of broaching sexuality, as well as having awareness around the taboo nature of it.

As Mollen et al. (2020) postulated in their paper, matters of sexuality coincide greatly with diversity factors due to sexual stigmatization of marginalized identities, making it important for clinicians to deepen and reflect their understandings of societal structures and their influences.

5. References

Anex, A., Dürrigl, M., Matthys, A., Felber, S., Medvedeva, T., Cleary, R., & Cleese, C. (2023). Guidelines, policies, and recommendations regarding the sexuality of individuals with severe mental disorders in psychiatric units, institutions, and supported housing across Europe: A systematic review: 121–134. *Archives of Sexual Behavior*, *52*(1). https://doi.org/10.1007/s10508-022-02430-4

Arczynski, A. V., & Burnes, T. R. (2025). Centering the unspoken: Intersectional sex positive clinical supervision. *The Clinical Supervisor*, *44*(2), 312–331. https://doi.org/10.1080/07325223.2025.254687

Barr, S. M., Snyder, K. E., Adelson, J. L., & Budge, S. L. (2022). Posttraumatic stress in the trans community: The roles of anti-transgender bias, non-affirmation, and internalized transphobia. *Psychology of Sexual Orientation and Gender Diversity*, *9*(4), 410–421. https://doi.org/10.1037/sgd0000500

Berger, I., & Ansara, Y. (2021). Cisgenderism. In *The SAGE encyclopedia of trans studies: A-L* (pp. 118–121). https://sk-sagepub-com.uaccess.univie.ac.at/ency/edvol/the-sage-encyclopedia-of-trans-studies/chpt/cisgenderism?term=cisgenderism

Boucher, M.-E., Groleau, D., & Whitley, R. (2016). Recovery and severe mental illness: The role of romantic relationships, intimacy, and sexuality. *Psychiatric Rehabilitation Journal*, *39*(2), 180–182. https://doi.org/10.1037/prj0000193

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2021). One size fits all? What counts as quality practice in (reflexive) thematic analysis? *Qualitative Research in Psychology*, *18*(3), 328–352. https://doi.org/10.1080/14780887.2020.1769238

Briken, P., Matthiesen, S., Pietras, L., Wiessner, C., Klein, V., Reed, G. M., & Dekker, A. (2020). Estimating the prevalence of sexual dysfunction using the new ICD-11 guidelines. *Deutsches Ärzteblatt International*, *117*(39), 653. https://doi.org/10.3238/arztebl.2020.0653

Brown, M., Tassie, E., Calisle, S., Covshoff, E., Ronaldson, A., Williams, J., Smith, S., Trevillion, K., Hughes, E., & Heslin, M. (2025). Barriers and facilitators to accessing sexual and reproductive health services for people with severe mental illness: A systematic review. *Social Psychiatry and Psychiatric Epidemiology*, *60*(6), 1283–1295. https://doi.org/10.1007/s00127-025-02844-0

Cruz, C., Greenwald, E., & Sandil, R. (2017). Let's talk about sex: Integrating sex positivity in counseling psychology practice. *The Counseling Psychologist*, *45*(4), 547–569. https://doi.org/10.1177/0011000017714763

Dziewanska-Stringer, C., D'Souza, H., & Jager, E. (2019). Understanding discrimination faced by transgender people in the health and social care settings. *European Journal of Public Health*, *29*(Supplement 4). https://doi.org/10.1093/eurpub/ckz186.667

Egan, S. K., & Perry, D. G. (2001). Gender identity: A multidimensional analysis with implications for psychosocial adjustment. *Developmental Psychology*, *37*(4), 451–463. https://doi.org/10.1037/0012-1649.37.4.451

European Institute for Gender Equality (n.d.) *heteronormativity*. Retrieved February 15, 2026, from https://eige.europa.eu/publications-resources/thesaurus/terms/1384?language_content_entity=en

Every third woman in the EU experienced gender-based violence. (2024). https://ec.europa.eu/eurostat/web/products-eurostat-news/w/ddn-20241125-3

Fahs, B., & Munger, A. (2015). Friends with benefits? Gendered performances in women's casual sexual relationships. *Personal Relationships*, *22*(2), 188–203. https://doi.org/10.1111/pere.12073

Giami, A. (2015). Between DSM and ICD: Paraphilias and the transformation of sexual norms. *Archives of Sexual Behavior*, *44*(5), 1127–1138. https://doi.org/10.1007/s10508-015-0549-6

Grunt-Mejer, K., & Lys, A. (2022). They must be sick: Consensual nonmonogamy through the eyes of psychotherapists. *Sexual and Relationship Therapy*, *37*(1), 58–81. https://doi.org/10.1080/14681994.2019.1670787

Hargons, C., Mosley, D. V., & Stevens-Watkins, D. (2017). Studying sex: A content analysis of sexuality research in counseling psychology. *The Counseling Psychologist*, *45*(4), 528–546. https://doi.org/10.1177/0011000017713756

Hendry, A., Snowden, A., & Brown, M. (2018). When holistic care is not holistic enough: The role of sexual health in mental health settings. *Journal of Clinical Nursing*, *27*(5–6), 1015–1027.

Heyder, A., Van Hek, M., & Van Houtte, M. (2021). When gender stereotypes get male adolescents into trouble: A longitudinal study on gender conformity pressure as a predictor of school misconduct. *Sex Roles*, *84*(1–2), 61–75. https://doi.org/10.1007/s11199-020-01147-9

Hill, A. V., Balascio, P., Moore, M., Wilson, T., Fields, A., & Miller, E. (2025). How racism and discrimination impacts black young women's sexual health: The influence of racial and sexual stereotypes on educational access. *Journal of Adolescent Health*, *76*(2), 316–322. https://doi.org/10.1016/j.jadohealth.2024.10.009

Kisler, T. S., & Lock, L. (2019). Honoring the voices of polyamorous clients: Recommendations for couple and family therapists. *Journal of Feminist Family Therapy*, *31*(1), 40–58. https://doi.org/10.1080/08952833.2018.1561017

Kraus, F. (2017). The practice of masturbation for women: The end of a taboo? *Sexologies: European Journal of Sexology*, *26*(4), e35–e41. https://doi.org/10.1016/j.sexol.2017.09.009

Lelutiu-Weinberger, C., Filimon, M. L., Chiaramonte, D., Leonard, S. I., Dogaru, B., Pana, E., Pruneanu, C., & Pachankis, J. E. (2025). A pilot trial of an LGBTQ-affirmative cognitive-behavioral therapy for transgender and gender expansive individuals' mental, behavioral, and sexual health. *Behaviour Therapy*, *56*(4), 723–737. https://doi.org/10.1016/j.beth.2024.10.005

Love, M., & Farber, B. A. (2017). Let's not talk about sex. *Journal of Clinical Psychology*, *73*(11), 1489–1498. https://doi.org/10.1002/jclp.22530

Ludwig, J., Brunner, F., Wiessner, C., Briken, P., Gerlich, M. G., & von dem Knesebeck, O. (2023). Public attitudes towards sexual behavior–Results of the German Health and Sexuality Survey (GeSiD). *PloS One*, *18*(3), e0282187. https://doi.org/10.1371/journal.pone.0282187

Machette, A. T., & Montgomery-Vestecka, G. (2023). Applying sexual scripts theory to sexual communication discrepancies. *Communication Reports*, *36*(2), 123–135.

McCann, E., Donohue, G., de Jager, H., Nugter, A., Stewart, J., & Eustace-Cook, J. (2019). Sexuality and intimacy among people with serious mental illness: A systematic review of qualitative research. *JBI Database of Systematic Reviews and Implementation Reports*, *17*(1), 74–125. https://10.11124/JBISRIR-2017-003824

McQuillan, M. T., Kuhns, L. M., Miller, A. A., McDade, T., & Garofalo, R. (2021). Gender minority stress, support, and inflammation in trans gender and gender-nonconforming youth. *Transgender Health*, *6*(2), 91–100. https://doi.org/10.1089/trgh.2020.0019

Miller-Perusse, M., Horvath, K. J., Kahle, E., & Stephenson, R. (2022). Gender minority stress, resilience, and psychological distress: The role of resilience among transgender and gender diverse youth. *Transgender Health*, *9*(4), 37–316. https://doi.org/10.1089/trgh.2022.0117

Mollen, D., Burnes, T., Lee, S., & Abbott, D. M. (2020). Sexuality training in counseling psychology. *Counselling Psychology Quarterly*, *33*(3), 375–392. https://doi.org/10.1080/09515070.2018.1553146

Montejo, A. L., Montejo, L., & Baldwin, D. S. (2018). The impact of severe mental disorders and psychotropic medications on sexual health and its implications for clinical management. *World Psychiatry*, *17*(1), 3–11. https://doi.org/10.1002/wps.20509

Morris, E. R., Lindley, L., & Galupo, M. P. (2020). "Better issues to focus on": Transgender microaggressions as ethical violations in therapy. *The Counseling Psychologist*, *48*(6), 883–915. https://doi.org/10.1177/0011000020924391

Nimbi, F. M., Galizia, R., Rossi, R., Limoncin, E., Ciocca, G., Fontanesi, L., Jannini, E. A., Simonelli, C., & Tambelli, R. (2022). The biopsychosocial model and the sex-positive approach: An integrative perspective for sexology and general health care. *Sexuality Research & Social Policy*, *19*(3), 894–908. https://doi.org/10.1007/s13178-021-00647-x

Quinn-Nilas, C., & Kennett, D. J. (2018). Reasons why undergraduate women comply with unwanted, non-coercive sexual advances: A serial indirect effect model integrating sexual script theory and sexual self-control perspectives. *The Journal of Social Psychology*, *158*(5), 603–615.

Renken, N. D., & Saucier, D. A. (2024). Masculine honor beliefs and perceptions of male rape. *Psychology of Men & Masculinity*, *25*(3), 275–289. https://doi.org/10.1037/men0000470

Rodgers, K. B., Hust, S. J. T., Li, J., Kang, S., & Garcia, A. L. (2023). Sexual scripts and sexual consent: Gender stereotypes, music-media messages, and sexual consent expectancies among college men and women. *Journal of Interpersonal Violence*, *38*(15–16), 9264–9289. https://10.1177/08862605231165766

Sahaluk, J. K., Todd, L. M., Milhausen, R., & Lachowsky, N. J. (2014). Dominant heterosexual sexual scripts in emerging adulthood: Conceptualization and measurement. *Journal of Sex Research*, *51*(5), 516–531. https://doi.org/10.1080/00224499.2012.745473

Sandbakken, E. M., Skrautvol, A., & Madsen, O. J. (2022). 'It's my definition of a relationship, even though it doesn't fit yours': Living in polyamorous relationships in a mononormative culture. *Psychology & Sexuality*, *13*(4), 1054–1067. https://doi.org/10.1080/19419899.2021.1982755

Seitz, T., Ucsnik, L., Kottmel, A., Blitzer, J., Teleky, B., & Löffler-Stastka, H. (2020). Let us integrate sexual health—Do psychiatrists integrate sexual health in patient management? *Archives of Women's Mental Health*, *23*(4), 527–534. https://doi.org/10.1007/s00737-019-01016-9

Simon, W., & Gagnon, J. H. (1986). Sexual scripts: Permanence and change. *Archives of Sexual Behavior*, *15*(2), 97–120. https://doi.org/10.1007/bf01542219

Simon, W., & Gagnon, J. H. (2003). Sexual scripts: Origins, influences and changes. *Qualitative Sociology*, *26*(4), 491–497. https://doi.org/10.1023/B:QUAS.0000005053.99846.e5

Southall, D. J. L., & Combes, H. A. (2022). Clinical psychologists' views about talking to people with psychosis about sexuality and intimacy: A Q methodological study. *Sexual and Relationship Therapy*, *37*(4), 512–536. https://doi.org/10.1080/14681994.2020.1749255

Stockman, D., Verhofstadt, L., Van Parys, H., De Mol, J., Littleton, H., Keygnaert, I., Lemmens, G., & Uzieblo, K. (2025). Coping with sexuality following adult sexual violence: A qualitative interview study of adult survivors' experiences. *Traumatology (Tallahassee, Fla.)*, *31*(2), 325–336. https://doi.org/10.1037/trm0000521

Symons, K., Ponnet, K., Walrave, M., & Heirman, W. (2018). Sexting scripts in adolescent relationships: Is sexting becoming the norm? *New Media & Society*, *20*(10), 3836–3857. https://doi.org/10.1177/1461444818761869

Tennille, J., Bohrman, C., Barrenger, S., Compton, E., Meduna, E., & Klein, L. (2022). Behavioral health provider attitudes and beliefs about sexuality and intimacy: Findings from a mixed method design. *Community Mental Health Journal*, *58*(3), 444–453. https://doi.org/10.1007/s10597-021-00838-1

Traumer, L., Jacobsen, M. H., & Laursen, B. S. (2019). Patient's experiences of sexuality as a taboo subject in the Danish health care system: A qualitative interview study. *Scandinavian Journal of Caring Sciences*, *33*(1), 57–66. https://doi.org/10.1111/scs.12600

Urry, K., Chur-Hansen, A., & Khaw, C. (2019). 'It's just a peripheral issue': A qualitative analysis of mental health clinicians' accounts of (not) addressing sexuality in their work. *International Journal of Mental Health Nursing*, *28*(6), 1278–1287. https://doi.org/10.1111/inm.12633

Valved, T., Kosakowska-Berezecka, N., Besta, T., & Martiny, S. E. (2021). Gender belief systems through the lens of culture-differences in precarious manhood beliefs and reactions to masculinity threat in Poland and Norway. *Psychology of Men & Masculinity*, *22*(2), 265–276. https://doi.org/10.1037/men0000331

VERBI-Software. (2021). *MAXQDA 2024* [computer software]. VERBI Software. maxqda.com.

World Health Organization. (n.d.-a). *Sexual Health*. Retrieved February 15, 2026, from https://www.who.int/health-topics/sexual-health#tab=tab_1

World Health Organization. (n.d.-b). *Sexual Health*. Retrieved February 15, 2026, from https://www.who.int/health-topics/sexual-health#tab=tab_2

World Health Organization. (2016). *International statistical classification of diseases and related health problems* (10th ed.). https://icd.who.int/browse10/2016/en

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th ed.). https://icd.who.int/

6. Appendix

6.1. Abstract

Purpose: Sexuality and sexual health are vital parts of being human and contributors to overall wellbeing, yet it is rarely discussed in clinical psychological settings. The discourse about sexuality with mental health professionals has not been studied much in German speaking samples. The purpose of this study was to examine the barriers clinical psychologists in Austria experience in terms of talking about sexuality with their clients, what sex education of professionals looked like, as well as to determine a professional attitude towards sexuality.

Methods: Eight clinical psychologists aged 30-53 in Austria, Vienna were recruited via national mental health websites, as well as their own websites. Semi-structured interviews were conducted inquiring understanding of the discourse about sexuality in clinical settings, the sex education of mental health professionals in Austria, as well as their definition of a professional attitude towards sexuality. The interviews were transcribed via AI and then coded with the software MAXQDA. The codes were analyzed using reflexive thematic analysis to identify emerging themes.

Results: Four themes emerged as follows: (1) Sexuality: Multifaceted and culturally taboo; (2) Talking about sexuality with mental health professionals is dependent upon clients, psychologists, their relationship and professional knowledge; (3) Professionally talking about sexuality: Reflect, seek feedback, or cause harm; (4) Heterogeneity of psychological training: Diverging opinions and lack of knowledge.

Discussion: Sex education needs to be incorporated more in basic training of mental health professionals to fuel conversations about sexuality, as well as skills and confidence. Furthermore, a sex-positive approach to sexuality needs to be adapted to provide better support for the complexities of sexual realities, as well as marginalized groups and account for systemic injustices.

Abstract

Ziel: Sexualität und sexuelle Gesundheit sind wichtige Bestandteile des Menschseins und tragen zum allgemeinen Wohlbefinden bei, werden jedoch in klinisch-psychologischen Settings selten thematisiert. Der Diskurs über Sexualität mit Fachleuten für psychische Gesundheit wurde in deutschsprachigen Stichproben bisher kaum untersucht. Der Zweck dieser Studie war es, die Hindernisse zu untersuchen, denen klinische Psycholog*innen in Österreich beim Thema Sexualität gegenüber ihren Klient*innen begegnen, sowie die Sexualaufklärung von Fachleuten zu beleuchten und eine professionelle Haltung gegenüber Sexualität zu ermitteln.

Methodik: Acht klinische Psycholog*innen im Alter von 30 bis 53 Jahren aus Wien, Österreich, wurden über bundesweite Websites für Fachpersonen zum Thema psychische Gesundheit sowie über ihre eigenen Websites rekrutiert. Es wurden halbstrukturierte Interviews durchgeführt, in denen das Verständnis des Diskurses über Sexualität in der klinisch-psychologischen Praxis, die Sexualaufklärung von klinischen Psycholog*innen in Österreich sowie ihre Definition einer professionellen Haltung gegenüber Sexualität untersucht wurden. Die Interviews wurden mittels KI transkribiert und anschließend mittels MAXQDA kodiert. Die Kodierungen wurden mittels reflexiver thematischer Analyse ausgewertet, um sich abzeichnende Themen zu identifizieren.

Ergebnisse: Es kristallisierten sich folgende vier Themen heraus: (1) Sexualität: Vielschichtig und kulturell tabuisiert; (2) Das Gespräch über Sexualität mit klinischen Psycholog*innen hängt von den Klient*innen, den Psycholog*innen, ihrer Beziehung und fachlichem Wissen ab; (3) Professionell über Sexualität reden: Reflektieren, Feedback einholen oder Schaden anrichten; (4) Heterogenität der psychologischen Ausbildung: Unterschiedliche Meinungen und mangelndes Wissen.

Diskussion: Sexualaufklärung muss stärker in die Grundausbildung von Fachkräften im Bereich der psychischen Gesundheit integriert werden, um Gespräche über Sexualität sowie Fähigkeiten und Selbstvertrauen zu verbessern. Darüber hinaus sollte ein sexpositiver Ansatz in Bezug auf Sexualität implementiert werden, damit die Komplexität von sexuellen Realitätswelten und marginalisierten Gruppen besser unterstützt wird und systemische Ungerechtigkeiten berücksichtigt und reflektiert werden.

6.2. Translation of quotations

1) *Ja, (ähm) weil ich glaub, das hat sehr viel mit familiärer Bildung, (ähm) (ähm) also die Art und Weise, wie zu Hause kommuniziert wird, wie darf ich zu Hause über meine Geschlechtsteile sprechen, (ähm) wie wie wie ziehe ich mich an zu Hause? Oder sind alle schambesetzt? Habe ich meine Eltern schon mal nackt gesehen? (Ahm) Was weiß ich darüber? (Ahm) Wie ist es im Kindergarten? Also, wie wird da damit umgegangen? (Ahm) Also, wie gibt es einfach Bewertungen von außen auf das eigene Geschlechtsorgan? (Ahm) Wie werden Körperlichkeiten, was gibt es für unterschiedliche Formen von Körpern? (P7)*
2) *Na ja, also immer wenn es um Hemmungen geht, ne, natürlich, also was ist, was ist normal, was ist richtig, was gehört sich, ne, was ist eben normale Sexualität, ne, also Erregungskonzepte können sehr unterschiedlich sein oder sein oder was jemand erregend findet, ne, und es gibt halt was das gesellschaftlich vielleicht eher (ähm) akzeptiert wird, als was anderes, ne. Also ist oder was man lernt, das okay ist oder nicht okay ist, ne...(P8)*
3) *Was möchte ich und was ist mir eigentlich zu viel? Wo tu ich nur was, wenn ich denk, das gehört so. Bei Frauen, da hör ich oft, dass das dem Mann gefällt, dass der dann ZUFRIEDEN ist. Männer haben das Thema auch, ne, dass ich PERFORME und das abliefere und erst wenn die Frau einen Orgasmus hat, dann ist das gelungen. (P8)*
4) *Ich glaub, dass auch schwer ist, alle Sachen abzudecken, aber man hat natürlich mit, mit das Sexualität ist ja immer was, was jeder hat. Also jede Person hat irgendwie eine Sexualität, (ähm) auch wenn es eine Asexualität ist, ist ja eine Sexualität und das das war tatsächlich sehr wenig, Thema. (P4)*
5) *Oder ja, also sind Lernprozesse, ja. (..) Also, Sexualität ist gelernt, (ähm) ist auch ein lebenslanges Lernen wie alles andere auch. (P6)*
6) *(..) Das ist jetzt nUr eineeee Idee von mir, weil ich es nicht weiß, aber ich glaube, dass es wahrscheinlich bei jüngereen (ahm) Patientinnen eher angesprochen wird aus dem Vorurteil heraus, dass es im Alter weniger wichtig ist oder aus dem TEILWEISEN Vorurteil heraus, dass es im Alter weniger wichtig ist. (.) Ich glaube, dass im Durchschnitt wahrscheinlich ältere Menschen EHER sagen würden, Sexualität ist mir nicht SO wichtig wie früher zum Beispiel, was aber natürlich nicht heißt, dass es NICHT wichtig ist. (P3)*
7) *Top 3 für Männer ist eine Errektionsstörung, vorzeitiger Samenerguss und na ja, Platz 3. (.) (Ah) Ist nicht ganz klar, hätte ich gesagt (lacht). (Ahm) Bei den Frauen ist eigentlich Orgasmus immer wieder. (.) Aber auch Lustlosigkeit. Eigentlich habe ich Top 2 pro Geschlecht (lacht). Und alles andere sind ein bisschen Abweichungen davon oder- es gibt auch seltenere Themen, (ahm) (.) wo alles Mögliche dabei ist (lacht). (P6)*
8) *Das größte Thema der Sexualität ist leider, (äh) ich habe sehr viele Klientinnen, die sexuelle Gewalt in der Kindheit erlebt haben oder auch sexuelle Gewalt in der Partnerschaft. (P5)*

9) *Ich glaube ganz viieel die Sprache. Also wie formuliere ich was? Das ist weder zu, weil das ist tatsächlich eine kleine Gratwanderung, glaube ich, da kann man sich auch mal ein bisschen anpassen ans Gegenüber. (P4)*

10) *Aber wenn es irgendwelche eigenen Themen gibt, das ist ja generell so, wenn es eigene Themen gibt, dann sollte man die als Psychologe hat man ein bisschen auch so die ethische Verpflichtung, sollte man das auch bisschen alles aufarbeiten. Man muss sie nicht übertragen auf Klienten Ja. Das gilt natürlich besonders für den Bereich Sexualität, hätte ich gesagt. (P6)*

11) *Das darf sein und und das darf nicht sein. (nachahmend) Das heißt, das ist so eine rigide Vorstellung von Sexualität und Beziehung, wie sie gelebt werden darf und wie sie richtige ist, wie es halt von vornehmlich konservativen Kreisen vertreten wird, während Sexpositivität halt eben eine eine liberalere, bedürfnisorientierte Herangehensweise an Sexualität einfach darstellt, ne? Und Bedürfnisorientierung halt wirklich dem, Jedem Individuum gerecht werdend, eben nicht wieder so ein (.) Das Schema A. ist das Alte und das Schema B. Ist das Neue, sondern es ist eben was, was immer in Verhandlung ist. (P2)*

12) *(Ahm) Also, ich hab keine (ähm) Seminare gehabt, also in meiner Ausbildung, wo also wo es jetzt wirklich wo Fokus war (ähm) Sexualität. Ja, also ich hab dann selber (ähm) Thema (ähm) L… Ich ..L.B.T.I.Q. +, ja, (ähm) Veranstaltungen oder Fortbildungen besucht. Um mich da einfach auch fortzubilden, gar nicht weil das eben mein Schwerpunkt ist, sondern einfach um was darüber zu wissen, weil ich ja nicht weiß, wer kommt zu mir in die Diagnostik und was, was ist dann da, wenn ich überhaupt nicht weiß, was was die für Bedürfnisse mitbringen. (P7)*

13) *Ja, eigentlich gehört das in den universitären Diskurs rein, also gar nicht, es ist sowas, sowas, wenn wir uns die die Grundbedürfnisse anschauen, ne. (P2)*

14) *Hängt natürlich immer vom Ziel der Diagnostik ab, aber grundsätzlich ja. Also wenn Sie so fragen, ob das Thema unterrepräsentiert ist in den bestehenden Instrumenten auch, ja, denke ich schon. (.) Und (ahm) es ist halt immer für mich so ein bisschen Gratwanderung, es ist übertrieben, aber einfach man muss so einen Mittelweg suchen, einerseits die Tatsache, dass es sich um ein tabuisiertes Thema handelt, zu respektieren und auch damit umzugehen und andererseits es ein Stück weit zu enttabuisieren. (P3)*

15) *Ja, wenn wenn einfach Heterosexualität VORAUSGESETZT wird und eine Patientin aber mit einer Frau verheiratet ist und die ganze Ambulanz nicht weiß, was sie jetzt tun soll. (P1)*

6.3. Interview guideline

Wir führen heute ein sogenanntes narratives Interview, es geht dabei vor allem um Ihre eigenen Erfahrungen und Meinungen, es gibt also keine falschen Antworten. Ich habe einige Leitfragen mitgebracht, um eine grobe Struktur vorzugeben, es geht aber vor allem darum, Sie erzählen zu lassen und Ihre Gedanken nachzuvollziehen. Die Teilnahme ist komplett freiwillig - wenn eine Frage unangenehm ist oder Sie nicht darauf eingehen wollen, müssen Sie diese auch nicht beantworten. Sie können sich auch jederzeit dazu entscheiden, das Interview abzubrechen.

Ich würde außerdem gerne eine Audioaufnahme von dem Interview aufzeichnen, damit ich es nachher transkribieren und für die Auswertung heranziehen kann. Die Daten werden natürlich anonymisiert, das heißt, es ist nicht möglich, auf Sie als Person Rückschlüsse zu ziehen. Sind Sie damit einverstanden?

Meine Fragen beziehen sich auf Ihre Sichtweise zum Diskurs über Sexualität in der klinisch-psychologischen Praxis. Bitte erzählen Sie mir einfach alles, was Ihnen dazu einfällt und was Sie für wichtig halten. Ich werde Sie möglichst nicht unterbrechen und erst nachfragen, wenn Sie fertig sind. Das Interview ist grob in 3 Teile geteilt: Im ersten Teil geht es um den generellen Diskurs über Sexualität in Ihrem Arbeitsalltag; Im zweiten Teil um die klinisch-psychologische Ausbildung und was Sie da gelernt haben; und im dritten Teil geht es um die professionelle Haltung gegenüber Sexualität. Wenn ich während des Gesprächs nach unten schaue, mache ich mir gerade Notizen, Sie haben aber dennoch meine ganze Aufmerksamkeit. Das Interview wird etwa 60 bis 90 Minuten dauern. Haben Sie noch irgendwelche Fragen oder ist soweit alles klar?

Können Sie mir zur Einordnung sagen, wie lange Sie schon als klinische*r Psycholog*in tätig sind, welchen Arbeitsschwerpunkt/Arbeitsschwerpunkte Sie haben und ob es Personengruppen gibt, mit denen Sie vorrangig arbeiten? Ok, dann geht es jetzt mit den inhaltlichen Fragen los.

Ich möchte Ihnen zuerst die Definition von Sexualität sagen, mit der ich in der Masterarbeit arbeite, damit wir auf einem gemeinsamen Nenner sind: Sexualität ist ein zentraler Aspekt vom Menschsein, der viele verschiedene Facetten, wie Geschlechtsidentität und Rollenverständnisse, sexuelle Orientierung, Sexualverhalten, Erotik und Intimität umfasst. Sexualität wird erlebt und ausgedrückt durch verschiedenste Dinge, wie Gedanken, Fantasien, Einstellungen, Verhalten und Beziehungen. Inwieweit all diese Dimensionen ausgelebt werden dürfen und auch wer diese Dimensionen ausleben darf, ist durch Faktoren wie Kultur, Ökonomie, Geschichte und Religion geprägt.

1. Wenn Sie jetzt an ihren Arbeitsalltag denken – Wie oft reden Sie da über Sexualität?

a. Was sind Themen die oft aufkommen?

b. Von wem werden die Konversationen im Schnitt öfter initiiert?

c. Sehen Sie einen Unterschied im Bedarf über Sexualität zu sprechen in der Diagnostik und in der Behandlung? Sollte es ihrer Meinung nach da einen geben?

d. Haben Sie sich selbst schon einmal dabei beobachtet, dass Sie Fragen bzgl. Sexualität bewusst weggelassen oder „durch die Blume“ versucht haben zu formulieren, weil Sie gewisse Annahmen über die Identität oder Offenheit ihres*ihrer Klient*in hatten?

e. Haben Sie das Gefühl, dass es eine gewisse Klient*innengruppe gibt, mit denen Sie eher oder öfter über Sexualität sprechen? Wenn ja, wie würden Sie diese beschreiben?

2. Wenn Sie sich jetzt an ihre Klinische Ausbildung zurückerinnern – Was haben Sie in dieser in Bezug auf Sexualität gelernt? a. Wie hat Sie diese auf den Umgang damit vorbereitet?

b. Was sind Themen, wozu Sie gerne noch mehr wissen möchten?

c. Bei welchen Themen sehen Sie es als besonders wichtig an, darüber informiert zu sein?

d. Haben Sie irgendwelche Zusatzausbildungen mit Schwerpunkt Thema Sexualität gemacht? Was hat Sie dazu veranlasst?

e. Fühlen Sie sich insgesamt mit dem Wissen, was sie durch die Ausbildung erworben haben, adäquat vorbereitet auf den praktischen Umgang damit?

f. Spielen gesellschaftliche Normen bzgl. Sexualität in Ihrer Arbeit eine Rolle? (Warum / warum nicht?) – Haben Sie dazu ein konkretes Beispiel?

g. Haben Sie die Veränderungen von ICD-10 auf ICD-11 in Bezug auf sexuelle Gesundheit mitbekommen? (Z.B. die Ersetzung von „Transsexualismus“ als Diagnose durch „Geschlechtsinkongruenz“ und die anderweitige Verortung der Diagnose, weg von dem Kapitel „psychische Störungen“) - Spielt das für sie eine Rolle in der Arbeit? Beschäftigt sie das?

h. Hat sich Ihr Verhältnis zu Sexualität durch die Ausbildung oder die Arbeit verändert? Inwiefern?

3. Was bedeutet es für Sie, eine professionelle Haltung gegenüber Sexualität einzunehmen? Wie sieht diese Ihrer Meinung nach aus?

a. Gibt es Ressourcen oder anderweitige Unterstützungen, die Sie sich in diesem Kontext noch wünschen würden?

b. Haben Sie schon einmal was von Sexpositivität gehört? Wenn ja, in welchem Kontext? Was bedeutet der Begriff für Sie? Wenn nein, was können Sie sich darunter vorstellen? →$

c. Glauben Sie, dass eine sexpositive Haltung ein hilfreicher Zugang zur Arbeit mit Klient*innen sein kann?

d. Gibt es Dinge, die Sie in der Ausbildung in dieser Hinsicht verbessern würden? Was würden Sie jungen/neuen Klinischen Psycholog*innen in dieser Hinsicht raten?

Vielen Dank, damit sind wir mit meinen Fragen durch! Gibt es noch irgendetwas, was Ihnen wichtig wäre und bisher nicht erwähnt wurde? Dann beende ich jetzt die Aufnahme. (ggf. hier soziodemografischen Kurzfragebogen geben, Fragen zur Studie beantworten, Zusendung der Transkripte und der Masterarbeit anbieten)

$ -> Damit Sie und ich ein ähnliches Verständnis von Sexpositivität haben, möchte ich gerne kurz die Definition, mit der ich in meiner Masterarbeit arbeiten werde, erzählen: Sexpositivität ist geprägt von Offenheit und Respekt gegenüber sexuellen-, sowie verschiedenen Geschlechtsexpressionen. Sie versucht urteilsfrei zu sein und respektiert persönliche Autonomie, zentralisiert Konsens, hebt die Validität von Geschlechtsidentitäten hervor und fokussiert sich auf Gesundheitsvorsorge und Bildung. Nachdem Sie jetzt diese Definition gehört haben, glauben Sie…

6.4. Consent form interview

Teilnehmer*inneninformation und Einwilligungserklärung zur Teilnahme an der Studie: „Let's talk about sexuality: A holistic approach to clincial practice in Austria"

Hier erhalten Sie Informationen dazu, wie die Studie abläuft, welche Zwecke sie verfolgt, welche Daten dabei erhoben werden und wie diese Daten gespeichert und verarbeitet werden.

Zweck der Studie

Es geht darum, zu verstehen, welche Kommunikationsbarrieren es bzgl. des Redens über Sexualität in der klinisch-psychologischen Praxis gibt, sowie darüber was klinische Psycholog*innen über Sexualität gelernt haben, wie dies ihre Arbeit beeinflusst und welche Änderungen, falls erwünscht, vorgenommen werden sollten.

Ablauf der Studie

Das Interview findet in Person statt. Wie auf dem Informationsblatt beschrieben werden Sie gebeten, von ihrem Praxisalltag und den Umgang mit Themen der Sexualität zu erzählen. Insbesondere interessiere ich mich für Ihre Meinung bzgl. Kommunikationsbarrieren von Sexualitätsthemen, sowie dafür, was sie in der klinischen Ausbildung über Sexualität gelernt haben und welchen Raum dabei die Reflexion über Normen eingenommen hat. Des Weiteren interessiere ich mich für eine Status-Quo Einschätzung und Änderungsvorschläge Ihrerseits.

- Das Interview wird ca. 60 - 90 Minuten dauern.
- Die Teilnahme ist freiwillig, Sie können es sich also jederzeit anders überlegen und entscheiden, dass Sie nicht mehr mitmachen möchten.
- Ihre Daten werden ausschließlich für wissenschaftliche Zwecke verwendet. Die Forschung verfolgt keine kommerziellen Interessen.

Datenerhebung, -verarbeitung und -speicherung

Das Interview wird mittels Handys aufgezeichnet. Im Anschluss wird die Aufnahme verschriftlicht. Die Aufnahme wird dann gelöscht. Bis zur Löschung wird die Aufnahme vertraulich behandelt. Sie wird nach Ende der Aufzeichnung in einen verschlüsselten Ordner auf meinem Server gegeben, auf den nur ich Zugriff habe. Niemand kann verlangen, die Aufnahmen einzusehen. Die Aufnahme wird mit einem anonymen Code benannt, sodass Ihr Name darauf nicht

aufscheint. Sie wird getrennt von dieser Einverständniserklärung abgespeichert und kann damit nicht in Verbindung gebracht werden.

Die Textdatei wird anonymisiert: das heißt, Ihr Name wird darin nicht vorkommen, und auch keine anderen persönlichen Daten, die Sie vielleicht im Gespräch erwähnen. Die Datenauswertung läuft dann so ab, dass ich die verschriftlichten Interviews lese und im Hinblick darauf analysieren, ob bestimmte Themen, Argumente, Eindrücke etc. von mehreren Personen geteilt wurden, ob sich Gruppen in einzelnen Punkten widersprechen, etc.

Datenschutzerklärung der Universität Wien

Die Universität Wien ist Verantwortliche dieser Datenverarbeitung im Sinne der Datenschutzgrundverordnung (DSGVO). In Entsprechung der die Verantwortliche treffenden Informationspflichten ersuchen wir Sie um Kenntnisnahme der nachstehenden Mitteilung: Diese Datenverarbeitung erfolgt für nachstehende(n) Zweck(e):

- E-Mail-Adresse, unter der Sie uns kontaktieren

-Wird im Laufe der Studie verwendet, um Kontakt aufzunehmen (Interviewtermin vereinbaren, falls gewünscht nach der Studie Zusendung der Ergebnisse)

- Aufnahme des Interviews:

-Transkription

-Analyse im Rahmen einer Masterarbeit

Verantwortliche dieser Datenverarbeitung ist Eva Steinhäusler, B.Sc., a12029818@unet.univie.ac.at, betreut durch Harald Werneck, Ass.-Prof. Mag.rer.nat. Dr.phil. Den Datenschutzbeauftragten der Universität Wien erreichen Sie unter der Adresse: datenschutzbeauftragter@univie.ac.at Die Universität Wien verarbeitet im Rahmen der gegenständlichen Datenverarbeitung nachstehende Kategorien personenbezogener Daten:

- elektronische Kontaktdaten
- Aufnahme eines Interviews

Rechtsgrundlage(n) der Verarbeitung:

- Einwilligung der betroffenen Person
- § 2f Abs. 5 FOG

Wenn Sie Ihre E-Mail-Adresse nicht angeben und/oder der Verwendung aller Daten (Kontakt- sowie Interviewdaten) nicht zustimmen, ist eine Teilnahme an der Studie nicht möglich. Ihre E-Mail-Adresse wird nicht an Dritte weitergegeben und nur zum Zwecke der Organisation des Interviews verwendet. Die E-Mail-Adresse sowie die Aufnahme des Interviews werden nach Beendigung der Studie unverzüglich gelöscht.

Als Betroffene/-r der Datenverarbeitung haben Sie gegenüber der Universität Wien das Recht auf

- Auskunft,
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- Löschung,
- Einschränkung,
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Sie haben darüber hinaus die Möglichkeit, eine erteilte Einwilligung für die Datenverarbeitung jederzeit ohne Angabe von Gründen zu widerrufen. Auch können Sie sich, wenn Sie eine Datenverarbeitung für unzulässig halten, bei der österreichischen Datenschutzbehörde (www.dsb.gv.at) beschweren.

Möglichkeit zur Diskussion weiterer Fragen

Wenden Sie sich an die Studienleitung, Eva Steinhäusler B.Sc., a12029818@unet.univie.ac.at, wenn Sie weitere Fragen oder Klärungsbedarf haben.

Bitte unterschreiben Sie die Einwilligungserklärung nur

- wenn Sie Art und Ablauf der Studie vollständig verstanden haben,
- wenn Sie bereit sind, der Teilnahme zuzustimmen und
- wenn Sie sich über Ihre Rechte als Teilnehmer*in an dieser Studie im Klaren sind.

Einwilligungserklärung

Ich bin damit einverstanden, dass Eva Steinhäusler meine Daten zum Zweck der Studienteilnahme verarbeiten darf. Meine E-Mail-Adresse wird gelöscht, sobald der Zweck der Verarbeitung erreicht wurde. Das Transskript meines Interviews wird anonym gespeichert. Die Tonaufnahmen werden nach der Transkription gelöscht. Ich erkläre hiermit, dass ich über die Informationspflichten (Recht auf Auskunft/Berichtigung/Löschung etc.) gemäß Art. 12–21

Datenschutz-Grundverordnung aufgeklärt wurde und diese zur Kenntnis genommen habe. Ich willige freiwillig ein und weiß, dass ich meine Einwilligung jederzeit widerrufen kann (per E-Mail an a12029818@unet.univie.ac.at). Im Fall des Widerrufs werden alle bis zum Zeitpunkt des Widerrufs erhobenen personenbezogenen Daten unverzüglich gelöscht.

Optional (bitte ankreuzen; eine Teilnahme ist auch ohne Zustimmung hierzu möglich): Ich bin zudem damit einverstanden, dass das anonymisierte Transkript auf Anfrage auch anderen Forscher*innen im Sinne wissenschaftlicher Transparenz zugänglich gemacht wird.

__ ja __ nein

_____

(Datum, Unterschrift Teilnehmer*in)

6.5. Overview Themes, Topics and Codes

Theme	Topic	Codes
Theme 1 **Sexuality: Multifaceted and culturally taboo**	Religion, patriarchy and cultural norms: The trifecta of sexual taboo	Norms Socialization Taboos and inhibitions are tied to norms Cultural influence Norms = Guidelines Social media (porn) Social media Body ideals
	Sexuality between avoidance, discrimination and knowledge gaps	No sex education for women Women are censored the most Gender roles and effects Aversion and reactance More critical reflection of people who aren't cis-het Gaslighting of sexual assault survivors Sexuality gets reduced to hetero sex Double standards
	Sexuality: Building identity, relationships and society	Important part of life Resource Essential part of relationships Political Topic Lifelong learning process Different sexuality as a symptom of disease
Theme 2 **Talking about sexuality with mental health professionals is dependent upon clients, psychologists, their relationship and professional knowledge**	Social similarity and sexual transparency	Struggles Same sex constellations in therapy Men disregarding work boundaries Different sex therapy situations and their possibilities Gender difficulties Generational differences Sexuality is still a difficult topic and taboo Talking about sexuality - characteristics No inhibitions when it comes to talking about it Talking about it differently with different types of groups

	From classic problems to questioning everything: Changing trends and expression and openness of sexuality	Talking about sexuality - frequency Poly relationships and the challenges Topics: Trans and non binary people more present now Current political situation Most common topics Gender differences in poly relationships How things have changed Topic poly more present now Most common topics: younger people
Theme 3 **Professionally talking about sexuality: Reflect, seek feedback or cause harm**	Signaling openness while maintaining boundaries Sexpositivity: Useful tool or trend?	Ethics Boundaries are important Respecting boundaries of clients Importance of self-exploration Help clients reflect what they have learned Differenciating between own feminism and therapy Examing norms in supervision and intervision Professional attitude Pillars of sexpositivity Criticism of sexpositivity Sexpositivity as a trend Sexpositivity as a useful attitude
Theme 4 **Heterogeneity of psychological training: Diverging opinions and lack of knowledge**	Necessary knowledge and required self-reflection Available but hard to access: Barriers and future improvements for further training of clinicians	Different types of ways to do/live sexuality Basics of sexual health Necessary basics for all Missing knowledge Requirements for talking about sexuality Aren't fans of further training Criticisms of further training Not enough further training possibilities Lots of education outside of academic psychological realm

	Ridicule and respect: Professional norms around the role of sexuality in the clinical psychology community	What they have learned There's enough training possibilities Criticisms of education Wishes for the future Assessment of sexuality under certain circumstances There's no consensus on what's normal Sexuality seen as not important Criticisms of existing diagnostics manual and missing guidelines Sexuality should be assessed everywhere Big topic among colleagues - GFL Opinion of other psychs It's important to be well connected Different opinions on trans people Professionals struggle with interacting with queer people Insecurities about working with trans people

6.6. Statement of AI Use

Erklärung zur Verwendung von Künstlicher Intelligenz (KI)

Hiermit erkläre ich, dass ich die folgenden KI-Hilfsmittel zur Erstellung meiner Masterarbeit mit dem Titel [Let's talk about sexuality: A holistic approach to clinical practice in AUT] verwendet habe. Ich versichere, dass die Kennzeichnung der verwendeten KI-Hilfsmittel vollständig ist, inkl. Verwendungszweck, Produktname, als auch ggfs. Prompts und Outputs des KI-Hilfsmittels. Ich verantworte die Auswahl und die Übernahme sämtlicher Ergebnisse der von mir verwendeten KI-Hilfsmittel vollumfänglich selbst.

Verwendungszweck*	**Produktname des KI-Hilfsmittels**	**Ggfs. Prompt (Input) und Output des KI-Hilfsmittels**
[Verwendungszweck, z.B. Schreiben, Literaturrecherche, statistische Analyse]	[z.B. ChatGPT, Copilot, Gemini]	[z.B. A1; die Anhänge mit Verweis auf den entsprechenden hier angegebenen Code am Ende dieses Dokuments anfügen]
Stilistische Verfeinerung und Grammatik	Microsoft Editor	
Literaturverzeichnis	Zotero	
Transkribieren	Copilot	
Codieren	MAXQDA	
Übersetzung Zitate	Deepl	

* Hilfsmittel zur Überprüfung von Grammatik und Rechtschreibung oder der automatisierten Erstellung des Literaturverzeichnisses sind von dieser Erklärung ausgenommen.