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The perspectives of psychosexual therapists towards using play therapy techniques in sex and relationship therapy: A qualitative study

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Abstract

Play therapy is an intervention traditionally used with children that is beginning to be used with adults. One area of use is within the psychosexual context; however, there is an absence of empirical research in this area. This qualitative study explored therapists' perspectives on using play therapy techniques in psychosexual therapy. The 16 participants were either qualified or trainee psychosexual therapists. Data were collected through focus group interviews and analysed thematically. Four interlinking themes were identified: (1) playfulness already used but not recognised as play therapy; (2) delivery and receiving of play techniques; (3) attachment; and (4) well-being and social skills. Overall, participants believed there were benefits to using play therapy in the psychosexual context but that the therapeutic environment should be conducive to its use. Recommendations for practice include views about whether or not play therapy can be further developed and refined for use within the psychosexual context.

Keywords: play therapy; psychosexual; sex and relationship therapy; sexual problems; qualitative

1. Background

Play therapy has predominately been used with children and thus the majority of play theories are focused outside of the adult context. There is growing anecdotal evidence that psychosexual therapists are using play to increase the confidence and intimacy skills of their clients. However, there is no empirical literature on the use of play therapy within psychosexual therapy. Understanding this history and the rationale for play therapy with children provides a useful starting point for understanding its use within sex and relationship therapy. Play therapy has been described as an effective means of responding to the mental health needs of young children and it is widely accepted as a valuable and developmentally appropriate intervention (Homeyer and Morrison, 2008). Play was first introduced into therapy by Hug-Hellmuth (1919), and later Klein (1932), who used play as a way of bringing children into a therapeutic situation by helping them to feel comfortable. As Axline argued: "Play Therapy is based upon the fact that play is the child's natural medium of self expression. It is an opportunity which is given to the child to 'play out' his [sic] feelings and problems just as, in certain types of adult therapy, an individual 'talks out' his difficulties." (Axline, 1969, p. 9)

Play therapy with children includes techniques, or tools, such as art work, sand-tray, music, dance and puppets. Play therefore offers children the chance to express their experiences and emotions in a way that they were familiar with and in a nonthreatening environment. It has been recognised that adults also engage in play. Ward-Wimmer (2002) suggested that adult play should be considered an important part of life as play encourages adaptive behaviours such as creativity and integration of the mind and body. Schaefer and Greenberg (1997) devised a playfulness scale which categorised adults in terms of play "types": some are fun-loving with a great sense of humour; some enjoy silliness; some are musical; and some have a quirky personality. They argued that adults often fall into a playful state but do not realise when they are "playing." A theoretical basis for play therapy was provided by Hudson Allez (2009) who examined attachment theory and the ways that secure or insecure attachments can affect an individual's abilities to care, play and seek happiness later in life. She argued that attachment has an important role in developing a strong sense of self in the child and his/her understanding of others. "The attachment processes for providing a secure base for a child is vital to the survival of the species as it facilitates the emotional pairing between mother and child, which in turn leads to the protection of the infant during his most vulnerable years." (Hudson-Allez, 2009, p. 3)

As the caregiver and child play, their brains produce endogenous opiates which trigger positive feelings in the body and thus encourage bonding to the attachment figure (Hudson-Allez, 2009). And this is why a distressed child will seek her/his caregiver for comfort. Bowlby (1973) proposed that if the secure base was not there for the child, s/he would probably develop an insecure attachment and this would manifest in relationships during later childhood, adolescence and adulthood. He also argued that the distortions in thinking and feeling that occurred as a result of insecure attachments underpinned much dysfunctional relationships as well as individual psychopathology. Consequently, if a child did not develop a strong attachment with a significant other then s/he may not be able to have strong bonds in adulthood and possibly experience sexual and relationship problems (Ciocca et al., 2014).

In the psychosexual context therefore, play may be a useful tool for helping the client to build connections with other people and to develop their intimacy skills. Indeed, anecdotal evidence suggests that play techniques are being used in this context. However, to the best of our knowledge there is currently no empirical literature on play therapy in adult psychosexual therapy. The aim of this study was to explore the perspectives of sex and relationship therapists towards the use of play therapy in a psychosexual context. As the study was exploratory and we wanted to capture in-depth data, a qualitative study design was adopted.

2. Method

This focus group interview study was conducted in the North of England, and data were collected between March and April 2011.

2.1. Participants and recruitment

A convenience sample of psychosexual therapists was recruited through the Sheffield Society for the Study of Sexuality and Relationships (SSSSR) email distribution list. The SSSSR is a group that shares sexuality and relationship information for local sex and relationship practitioners. All therapists registered on SSSSR were contacted and invited to take part. Those who replied stating their interest were sent an information sheet and given the opportunity to talk to the first author and ask questions about the study. Inclusion criteria were broad; participants should be able to talk about their experiences of being psychosexual

therapists and no gender or age limits were imposed. Participants were practising therapists with experience of providing psychosexual therapy for adults who experienced sexual and relationship difficulties. The total sample (n16) included both male (n5) and female (n11) therapists, qualified (n5) or in training (n11). Recruiting therapists who were either qualified or in-training enabled a diversity of perspectives to be captured. Participants were aged between 25 and 60 years old and the majority described their ethnic group as White British. All 16 participants had at least secondary school education. See [Table 1](#) for further demographic information.

2.2. Data collection and analysis

All those who expressed an interest in taking part did so unless they were unavailable on the dates arranged for the focus groups. Participants took part in one of three focus group interviews. The three focus groups consisted of: (1) a mixed group of trainee and qualified psychosexual therapists; (2) a group of trainee psychosexual therapists; and (3) a group of qualified psychosexual therapists. Having three distinct groups enabled participants to choose which focus group they took part in: a decision made after a small number of trainee therapists suggested that they might not feel comfortable sharing their experiences in front of qualified staff. For practical reasons, each focus group interview was concluded within one hour as participants were limited in the time they could commit. As a way of introducing the topic, the first author presented a five minute summary of the background to the study (which formed the basis of the Masters project taken as part of her psychosexual training). Here play therapy, as it is used with children, was briefly explained to the participants. It is recognised that the summary presented may have “framed” the subsequent discussion, and influenced participants’ answers to the questions asked. The first author did not have any experience of using play in the psychosexual context, and thus, was conducting the research from an outsider perspective. As a trainee therapist there was a power imbalance when qualified therapists were in the groups. However, having an interview guide helped to keep the discussion focused on the areas we wanted to explore.

Table 1. Participant demographic.

<i>Participant</i>	<i>F.G. number</i>	<i>Qualified/trainee</i>	<i>Gender</i>
1	1	Qualified	Female
2	1	Qualified	Female
3	1	Trainee	Male
4	1	Trainee	Male
5	1	Trainee	Female
6	1	Trainee	Male
1	2	Trainee	Female
2	2	Trainee	Female
3	2	Trainee	Male
4	2	Trainee	Male
5	2	Trainee	Female
6	2	Trainee	Female
7	2	Trainee	Female
1	3	Qualified	Female
2	3	Qualified	Female
3	3	Qualified	Female

The focus group interviews followed a guided conversation style (Kvale, 1996), which included open-ended questions on the topic and space for participants to reflect on and

discuss issues they deemed relevant. The areas explored during the focus groups included views about using play therapy techniques in their own practice, client and therapist acceptability, the potential benefits and disadvantages of such techniques, and perceived barriers and facilitators to using play therapy in the psychosexual context. All the focus group interviews were conducted by the first author. After three interviews it became clear that no new data were disclosed, so the decision to not recruit more participants was made.

Data were analysed thematically following the procedure outlined by Aronson (1994). First, the interviews were listened to several times to ensure accuracy and to gain a deeper understanding of what the participants were saying. Next, the interviews were transcribed verbatim. The first author then read through the transcripts to identify patterns relating to both the topic and participants' emotions (Leininger, 1985). Subsequent analytic steps enabled the categorisation of the remaining data into themes. The patterns were categorised and refined so that some were merged with others, some deleted. One focus group interview was independently analysed by the first two authors who compared analyses to ensure agreement on coding decisions. Few discrepancies emerged and where they did, consensus was negotiated. This initial coding framework was then used as the basis from which the remaining two transcripts were analysed.

2.3. Research ethics

Ethical and research governance approvals were secured from the National Health Service Research Ethics Service and the local Trust. Prior to interview, participants were given reassurances of confidentiality and anonymity, the opportunity to ask questions, were told that they need not answer questions if they did not want to, and were informed of their right to withdraw from the study. The tape-recorded interviews were kept in a locked cabinet which only the researcher had access to, and were destroyed at the end of the study. When the interviews were transcribed, any identifying information was omitted to protect anonymity.

3. Findings

Four key themes were identified during analysis: (1) playfulness already used but not recognised as play therapy; (2) delivery and receiving of play techniques—sub theme qualities and skills of the therapist; (3) attachment; and (4) well-being and social skills. These interlinking themes are presented below and have been supported with excerpts from the interviews.

3.1. Playfulness already used but not recognised as play therapy

A key finding of the study was that participants already used playfulness in their work but did not recognise it as play therapy as such. This appeared to be because participants were thinking about the play of childhood thus not making the connection between that they used in a professional capacity. The pre-interview presentation which covered some play interventions helped to contextualise it within a therapy setting. Some of those play interventions were interesting for me because I haven't ever suggested it in a session. But I have suggested playing in the bath or seeking some kind of activity that is non-threatening, so it doesn't have to be sexual as long as they engage. (FG 3 Qualified, Female)

The participant above alludes to the safe nature of play, and that she has encouraged playfulness outside of the therapeutic environment. The point was made that play in the psychosexual context did not need to be sexually based, as any type of play would enable the clients to engage with their partners. This was based on the idea that play was a social

interaction, and a vehicle for expressing emotion while understanding the emotion of others. Similarly, the participant below made reference to playfulness as an alternative to sensate focus:

I had one couple and I thought similar to you, to do pre-sensate focus with them. You know, you want them to re-establish intimacy and they have to choose a game, so one liked playing darts so they played darts and the other was doing a jigsaw. And while they were doing the jigsaw they were doing it together and it wasn't threatening. But what was interesting when we came back they were able to talk about who was taking over and who was the time giver. (FG 3 Qualified, Female)

Other participants gave examples of how they used play with their clients. And it was clear that they encouraged playful activities as a way of connecting before or during sensate focus exercises which were used to increase intimacy in couples. Playfulness thus was perceived to increase intimate engagement with another person, and sensate focus to increase the sexual contact. In this way, playfulness was perceived to have potential benefits for clients through re-establishing intimacy in non-threatening way (further perceived benefits are discussed in Section 3.4).

3.2. Delivery and receiving of play techniques

Play was already used by some therapists but the way in which play therapy could be presented to the client was central to this theme. Participants voiced concern about potentially offending the client, who might associate play therapy with children and stated that very careful consideration was required about whether play would be appropriate for each individual client. Indeed, it was recognised that play therapy would not suit every client and that the therapist should be mindful of different types of models or activities to suit clients' needs. Further, if the client perceived that play therapy was being imposed as homework then they could feel threatened, which would be detrimental to the therapist-client relationship.

I think sometimes we don't realise, but it's like getting it in an adult context. Because often you're thinking of play therapy in a childish way, and therefore you might become fixed on childish things, so like cooking a romantic meal is still play but it's creative with an adult atmosphere. (FG 3 Qualified, female)

Play therapy should according to the participants be disconnected from the play of childhood, and thus reframed within an adult context for it to be received well. Indeed, it seemed that for play therapy to be effective both the client and therapist should think of play in the broader sense of being creative. The appropriate use of language was highlighted as important in the delivery of play therapy and ultimately how it would be received. Simply introducing the concept of play was not enough.

The one con [disadvantage] is that people might not want to do it especially because of the word 'play'. Even the concept of it might seem patronising. People might say: 'How do I know I am playing, what is play?' It could raise a lot of issues. (FG 1- Trainee, Male)

The issues it could raise related to whether or not a client had engaged in play as a child. If not, then this could lead to uncertainties about using play in the therapeutic context and ultimately raise a client's anxiety. This could be complicated by "play" being a loaded concept: it is linked with childhood, and being childish, but also difficult to define in an adult context.

I think it's important knowing where they are and what their perceptions are, of going to that child area. But I always reframe it to being child-like and not childish and that's something really magical. (FG 2- Trainee, Female)

The power of language itself can be enhanced in the therapeutic context, so a careful reframing of play could help the acceptability of play therapy within psychosexual therapy.

3.2.1. Qualities and skills of the therapist

The qualities and skills of the therapist were thus viewed as important because they could make a difference not only to the delivery of play therapy, but how it was received by the client. Participants talked about using inconspicuous techniques to re-introduce sex as more playful to their clients. In the excerpt below, the participant realised that it could take time for the connection between sex and play to be made by the client, but she believed it was the responsibility of the therapist to suggest sex in this way. This entailed challenging clients' defences and concerns around initiating intimacy.

It's the job of the therapist, how it could be more playful and even if it starts at one end of the spectrum there's no reason why sex can't move further along to be more playful. I sometimes say as people are going out the door 'Have fun' - quite often they don't when they start - in the hope they get used to it. Break down more barriers (FG 1- Qualified, Female)

Similar to breaking barriers that the clients might have, participants talked about crossing boundaries themselves. In terms of the latter, this was described as adapting what they had learnt during psychosexual training, drawing on other skills and finding out there are other ways to progress the therapeutic process. Indeed, and as evident in the excerpt below, creativity in the therapeutic context was a skill learned from observing a mentor at work.

I think you [another participant] are creative, very creative. When I worked with you, you taught me how to be a creative therapist. I think there is a difference, and I think it allows you to think in boundaries, to think that there is more than one way of doing therapy. (FG 3 Qualified, Female)

The implication is that without this teaching and learning experience the therapist may not have been aware of the benefits of using creativity as a "tool" in psychosexual therapy.

3.3. Attachment

Attachment was raised as an issue which could affect the likelihood of a client engaging in play therapy. It was highlighted that introducing play for those with insecure attachments could be harmful. But the potential to help a client to overcome these problems and to help them develop skills to build relationships was perceived to be very important.

If their attachments were dysfunctional in any way then you are giving them tools that they didn't have, you're creating a toolbox for them. And I like the idea of giving them permission to not think of it as a negative thing. (Focus group 3- Qualified Therapist)

The concept of creating a toolbox for clients, as well as giving them permission to use the tools, was shared by many of the participants. Play therapy could allow an individual to tap into skills that they have never used before, or to develop new ones, and thus to reframe play into a positive experience.

I'm really interested in play and I guess that's something to do with my training and therapy. I really believe that if you look at security and attachment you can then help a client in therapy. They could work through the difficult things, and if play will help that and then I think it's quite important. (Focus Group 3- Qualified Therapist)

In the excerpt above, the recognition that play therapy has the potential to benefit clients who have security and attachment issues is clear. The participant also identifies that play generally could help a client work through difficulties and thus it is viewed in a similar way to play therapy with children. Indeed, there was some recognition of play therapy with adults as one participant disclosed her work with Glenn Hudson Allez, and made the link between attachment theory and play.

Certainly with my clients I say to them that we may have an overload of logic and where has play gone in your lives. And that's why I am curious, I say curiosity because I am interested in learning more about this as I have worked a lot with Glenn and I've used attachment and transaction analysis. So play is really important because it's an area which I'm developing. (Focus group 3- Qualified Female)

The participant above was the only one to specifically say to clients that they should play. Further, she was exploring play as a therapeutic tool for clients with attachment issues. Nonetheless, while play or playfulness, was adopted by some participants in the adult psychosexual context, none of them defined their techniques as play therapy.

3.4. Well-being and social skills

The final theme focuses upon the perceived secondary benefits of play therapy for clients, in particular the potential to improve their sense of well-being as well as develop their social skills. Through safely acting out scenarios, skills could be developed which could help the client to deal with difficult situations.

One of the goals could be to increase self-esteem, but it could be to increase social skills, intimacy.

To understand a situation in conflict, to act it out, to react to what happened in a play context, however you choose to do that, but it's about enabling that to happen. (FG 3- Qualified, Female)

The therapist therefore plays a central role as the “enabler”: a role that, as above, would need to be very carefully managed if it was to be successful. But, again, the complexities of encouraging play with clients who have not engaged in play for a very long time was highlighted. In particular, that the “rules” of play usually learned in childhood may need to be learned anew.

Knowing when to stop playing which is part of therapy, it's part of boundaries, and how to say I don't want to play anymore because as children that's how we learn social skills, isn't it? Can I come and play or I don't want to play anymore and I don't think some of our adults have those skills, and they can learn those social skills through play therapy. (FG 3- Qualified, Female)

The view that play in the psychosexual context could help a client to recognise her/his own boundaries and learn about the boundaries of others was clear. Learning about boundaries was perceived to build confidence, and thus as having the potential to improve a client's social skills. Another benefit related to the physicality of some types of play which could have an impact on psychological well-being. The physical feelings that play can engender were seen to enable a connection with the body that clients may have lost or indeed never had. Learning to touch their own body, to recognise the various sensations and pleasures, is an important part of psychosexual therapy, so to do this in a nonsexual way could be a starting point.

Also laughter, seeing the therapist laugh. Maybe it shows the dimension in the room, who has the power in the room or who seems to have the power in the room. (FG 3 Qualified, Female)

Finally, seeing the therapist laugh was perceived to be helpful in that it could help to break down the power imbalance between therapist and client and thus encourage the development of a positive therapeutic alliance. It also was perceived to work as giving the client permission to laugh too.

4. Discussion

The findings of this study have provided a first step towards understanding how play therapy could be used in the psychosexual context. We identified that most participants used play within their work but did not associate it with play therapy. Indeed, many were able to discuss their experiences of using play, or at least what they interpreted as play, during their professional practice. Playfulness had been used mainly as a homework exercise, and often as a precursor to sensate focus. It was aimed therefore at encouraging the clients to feel comfortable engaging in the activities that would be required for the subsequent sensate focus. According to Leibulm and Rosen (2000), in sensate focus the therapist starts at a basic level with the client by, for example, suggesting that the couple take a bubble bath together. In this way, the participants in this study positioned play as something which built on sensate focus and offered more than the traditional recommendations allowed.

For many participants their personal experiences of providing therapy seemed to be an important factor in whether or not they would be willing to engage their clients in play. For example, some stated that the personality of the therapist could influence how creative they were in their work. Others expressed concern about around clients' interpretations of play. Facilitating the client-professional relationship was important to the participants, so not appearing to be patronising by suggesting play therapy was a key consideration.

But attachment difficulties were described by several of the participants as a reason why some clients might not engage in play. Participants expressed that part of the reason children play is because they are fearless and boundary free; however for adults this can be very different. For some clients they may have learned throughout their lives that there are consequences to their actions and they need to live within boundaries. Alternatively, they may never have learnt that at all. There was a view that clients with difficult attachments may experience benefits from play therapy to work through their difficulties. Hudson-Allez (2009) provided support for this finding by stating that over the formative years, a child builds her/his confidence with the help of their attachment figure. They learn that support and comfort is available whenever they desire. Considering this in an adult context, play therapy might be a way of encouraging clients to explore their attachment difficulties and help them to develop skills around giving and receiving love, support and care.

The process of exploring attachments may be frightening for some clients if they have never developed a secure attachment. It was suggested that play can help clients who have previously had dysfunctional attachment by providing them with tools for building stronger attachments. For many of the participants understanding their clients' attachments was a large part of their work and there was a lot of support for the idea that play could be used to explore this area. This finding is again supported by Hudson-Allez (2009) who examined the work on attachment from birth and how this may affect our abilities later in life to care, play and seek happiness. Many participants agreed that play therapy had the potential to enhance a client's well-being. When playing, participants described that clients might not take themselves too seriously and therefore would be able to laugh more, and perhaps embrace life in a different way. Interestingly, it was described that seeing the therapist laugh could also help the client with self-esteem as for many clients it might help equalise the power imbalance within the therapeutic relationship. These findings have been supported by Sultanoff (2003, p. 107) who argued that "humour in psychotherapy is curious concept; by integrating humour, generally a light, playful and in some cases a distracting experience, within psychotherapy which for many is a very serious process." Humour can have many benefits, such as its ability to change emotional distress and cognitive distortions as well as enhancing the therapeutic alliance (Sultanoff, 2003). Another finding of this study was the perceived benefit of helping clients to explore their bodies and learn to appreciate their own touch through play. This finding is supported by Ward-Wimmer (2002) who argued that play invites access to a state of well-being, calmness, silliness and joy. It seemed that playfulness in the psychosexual therapeutic context came from taking a creative approach to therapy; however some of the participants felt this was an area in its infancy and required further development.

4.1. Implications for practice

A number of implications for professional practice were identified from this study. First, as many participants in this study utilised play in their sessions but did not consider it to be play therapy, then there is chance that other psychosexual therapists are doing the same. Thus, giving a name to the techniques may help to further the development of play therapy in a psychosexual context. For example, if the techniques were labelled as a form of play therapy they could be evaluated and conclusions drawn about their efficacy. From that, appropriate training could be developed which, in turn, may work as a form of permission giving to the therapist to think and work more creatively. Leilbulm and Rosen (2000) suggested that psychosexual therapists should be creative particularly when they recommend sensate focus. The lack of education and training in play, as described by the participants in this study, could explain why some did not feel confident using play in therapy with their clients. However, the question of whether or not it would be useful to redefine what therapists already do as play therapy, or to adapt existing models of play therapy with children to work with adults in the psychosexual context, remains to be answered. Second, if play was to be used then recommendations include: create an environment that is conducive to play; be mindful of how play is introduced; and bear in mind that play may not be suitable for all clients. Finally, returning to the adult playfulness scale (Schaefer & Greenberg, 1997) mentioned in the Introduction, these categories might be useful for therapists to assess whether or not the client will respond positively to play. However, it is likely that this scale would need to be refined and validated for use in psychosexual therapy.

4.2. Study limitations

On reflection, the brief presentation at the start of the focus group interviews about the background to the study was useful in that it facilitated discussion. However, there is chance that it may have shaped how the participants understood and therefore talked about the topic. A further limitation of the study is that participants were recruited mainly from the North of England, thus the perspectives of therapists who work in other geographical areas, and who may have different ideas and experiences of play in psychosexual therapy, were not captured. It would be interesting to explore clients' perspectives about using playfulness and play therapy in the psychosexual context. Future research studies could be carried out to explore these issues and therefore build the evidence base around play and psychosexual therapy.

5. Conclusion

While play therapy in the psychosexual context forms a new direction in adult sexual and relationship therapy, the participants in this study were overall not averse to implementing play in their work. Indeed, the perceived benefits of play when used in this context included increasing a client's well-being and self-esteem, improving their attachment and social skills, and helping the client and her/his partner to regain intimacy. However, from the participants' perspectives it was clear that play therapy would not suit every client and may not be appropriate for every therapist, due to the complexities of play as learned, or not learned, in childhood. An interesting finding was that a number of the participants had been using play-type exercises with their clients but did not consider it as play therapy. This may be because this technique does not have a formal name or definition in the sex and relationship literature. While the findings of this qualitative study have captured the perspectives of qualified and trainee psychosexual therapists and added to the body of literature on psychosexual therapy with adult clients, the issues identified warrant further exploration to build up the evidence base.

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Disclosure statement

No potential conflict of interest was reported by the authors.

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References

Aronson, J. (1994). A pragmatic view of thematic analysis. *Qualitative report*, 2(1). Retrieved from <http://www.nova.edu/ssss/QR/BackIssues/QR2-1/aronson.html>

Axline, V. (1969). *Play therapy*. New York, NY: Ballantine Books.

Bowlby, J. (1973). *Attachment and loss, Volume 2 _ Separation: Anxiety and anger*. London: Hogarth Press.

Ciocca, G., Limoncin, E., Di Tommaso, S., Mollaioli, D., Gravina, G.L., Marcozzi, A., . . . Jannini, E.A. (2014). Attachment styles and sexual dysfunctions: A case-control study of female and male sexuality. *International Journal of Impotence Research*. doi: 10.1038/ijir.2014.33

Hellmuth, H. (1919). *A study of mental life of a child*. Washington, DC: Nervous and Mental Disease Publishing.

Homeyer, I., & Morrison, M. (2008). Play as therapy. *American Journal of Play*, 1(2), 210_228.

Hudson-Allez, G. (2009). *Infant losses; adult searches, a neural and development perspective on psychopathology and sexual offending*. London: Karnac Book.

Klein, M. (1932). *The psycho-analysis of children*. London: Hogarth Press.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. Los Angeles, CA: Sage.

Leiblum, S., & Rosen, R. (2000). *Principles and practice of sex therapy*. (3rd ed.) New York, NY: Guilford Press.

Leininger, M.M. (1985). Ethnography and ethnonursing: Models and modes of qualitative data analysis. In M.M. Leininger (Ed.), *Qualitative research methods in nursing* (pp. 33_72). Orlando, FL: Grune & Stratton.

Sultanoff, S.M. (2003). Integrating humour into psychotherapy. In C. Schaefer (Ed.), *Play therapy with adults* (pp. 107_140). New Jersey: John Wiley and Sons.

Schaefer, C., & Greenberg, R. (1997). Measurement of playfulness: A neglected therapist variable. *International Journal of Play Therapy*, 6, 21_31.

Ward-Wimmer, D. (2002). Introduction: The healing potential of adults at play. In C. Schaefer (Ed.), *Play therapy with adults* (pp. 1_10). New Jersey: John Wiley and Sons.