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RECOGNIZING THE IMPORTANCE OF SEX AND GENDER ISSUES AMONG POLISH PSYCHOTHERAPISTS

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gender
sex
psychotherapists

Summary

Objectives: Gender is the fundamental dimension of identity and therefore defining femininity/ masculinity and the related roles by psychotherapists seem to be especially important in psychotherapy practice. The presented research is one of the first of this kind in Poland and therefore is rather exploratory and descriptive in nature. The purpose of the study was to find the answer to the question whether Polish psychotherapists, in the understanding their patients, refer to their own gender and sex-related experiences in the process of psychotherapy and supervision and — if yes–how they reflect them.

Methods: The authors prepared a questionnaire including 20 closed and one open-ended question. The study involved 144 heterosexual psychotherapists (70% of females, 30% of males).

Results: The findings showed that psychotherapists in individual, family and couples psychotherapy refer to their gender-related experience particularly as a daughter/son, woman/man (younger therapist), mother/father (older therapist). For younger female and male heterosexual psychotherapists (up to 40 years old) working with an opposite sex, attractive patient is a challenge, which — in the case of male therapists — disturbs the process of psychotherapy, while in the case of female therapists may both disturb or — as they claim — facilitate it.

Conclusions: The life cycle of therapists and their sex seem to significantly influence the way they experience their patients and refer to gender issues of their patients. The results confirm the necessity of supervision due to the inner voices of psychotherapist related to sex and gender activated during psychotherapy.

Introduction

Gender is a concept describing a diverse set of behaviors, roles and expectations related to definition of femininity and masculinity, which developed as a result of postnatal psychological, sociological and cultural influences and which are constantly created and performed [1, 2]). Gender is not the same as sex, i.e. a set of physical traits and sexual behaviors resulting from different functions and roles of both sexes in the process of reproduction. Modern take on gender questions the assumed, constant link, present in the essentialist approach,

between biological sex and sexual identity: femininity/masculinity. Rather to the contrary, it emphasizes that gender is "a constituting identity", something that we constantly create in the process of performing behaviors and obeying the norms of a given social construct of gender, generally realized through body, behaviors, gestures, appearance, outfit, manner of communication and interaction ([2] p. 80, [3]). The concept of femininity/masculinity therefore describes complex constructs consisting of various experiences related to the roles assumed in life. Those experiences co-construct the dialogic self of an individual [4, 5].

The concept of a dialogical self assumes that a subject has at their disposal a number of inner voices that - while maintaining an inner dialogue - create a structure of a Self described as a *society of mind*. Gender-related experiences, including relations of dominance-submission in interpersonal contacts, in which a person functions in a culture, influence the way, in which a Self is organized. Some of those voices may become reinforced and preserved while others may be diminished or repressed. They are activated during the interactions and impact their course, often unconsciously. Studying gender-related voices seems to be especially important in the process of psychotherapy due to its relational nature and the importance of bonding and building alliance between a psychotherapist and a patient. Peter Rober [6, 7] points out that during a therapeutic session, in the mind of the psychotherapist both professional and personal voices might be activated. The latter is the *I for - myself* that contains personal memories, hopes and fantasies of a psychotherapist activated by what he or she observes during a session, while the *professional self* is filled with professional knowledge, active construction of hypotheses and getting prepared for an intervention. Among the personal voices, the ones referencing gender roles such as daughter/son, girl/boy, woman/man, spouse, father/mother seem to be the most important. In the case of activating the sex- and gender-related voices of a psychotherapist, his or her personal history should be taken into consideration, as well as the social and cultural context they live in and which impacts the way of thinking about gender-related roles. Studying inner voices is not an easy task; to the contrary, it is a real challenge for the contemporary researchers

Gender and sex research in psychotherapy

Research on the significance of gender and sex in psychotherapy has been carried out since the 70s of the last century and has covered different issues and perspectives. The basic ones concerned the impact of sex and gender on the formation of a therapeutic alliance, the way of conducting therapeutic sessions, topics and issues raised and covered during therapeutic sessions and on the effectiveness of psychotherapy [8-12]. At this point it should be noted that very often sex and gender tend to be used interchangeably in research which often leads to

confusion what is actually a subject of a study [13]. Additionally, research programs conducted in different periods, originating from different theoretical premises and based on different methodologies are difficult to compare. Nevertheless, Diane Gerhart and Randall Lyle [12] in their summary of qualitative and quantitative research projects point out that these projects "provide evidence that gender is a significant and one of ten subtle factors in therapy" [12 , p. 445). Although the research revealed that the results of psychotherapy do not depend on the sex of a patient; nevertheless, they showed, among others things, differences in the manner of conducting therapy by women and men, differences in patients' reactions depending on therapist's sex and differences in the topics and issues discuss in therapy when psychotherapist's sex is a factor [12, 14-16]. Stephanie Schields and Susan McDaniel [14] while examining first family interview discovered that male therapists talked more and tended to be more structuring or directive than female therapists. They observed that the engagement of a therapist and family in the "battle for structure" and control over the direction of the treatment during sessions run by a male therapist was stronger than during sessions run by a female therapist. In the presence of female therapists, families were more open to reveal disagreement and conflict. Werner-Wilson, Zimmerman and Price [16] while studying family and couples therapy interventions discovered that male therapists were more effective in introducing new topics during family sessions, while female therapists were more effective in doing so during couples therapy sessions.

Many research projects focus on finding out whether matching patient's and psychotherapist's gender is important in the process of building therapeutic relations and working alliance and whether this translates into the effectiveness of therapy [17-21]. Blow, Timm, and Cox [9] based on their review of research projects dedicated to the significance of matching patient's and psychotherapist's gender on the course of individual therapy, family therapy and couples therapy process showed that in the case of the first one, psychotherapist's gender did not have any impact on the effectiveness of therapy. Psychotherapy of adolescent patients with addiction problems was the only exception. Research by Wintersteen, Mensinger and Diamond [19] showed that chances of building a relationship and staying in therapy of teenage boys were much greater if the therapist was a male. On the other hand, male therapists experienced greater difficulties in working with addicted teenage girls. Research results also show that gender plays a significant role in family and couples therapy. Blow, Timm and Cox [9] say "in couples and family therapy gender is significant in terms of family reaction to therapist's sex and gender roles associated with that sex within the family. While no study has

connected the gender of the therapist to the successful outcome of a family or couples therapy, nevertheless it is likely that a therapist who is unable to negotiate gender tensions within a family will fail to help family members resolve their problems" [9, p.79]. Based on the review of numerous studies, Blow, Timm and Cox show that therapists of both genders experience difficulties in meeting the expectations of family members due to their gender and related stereotypes. Even when psychotherapists of different sex use the same therapeutical techniques, family members react in very different ways, often expecting stereotypical behaviors, e.g. caring from a female therapist, directive from a male therapist. The results of other research show that in family and couples therapy we may observe gender-based inequalities and gender stereotypes exhibited also by psychotherapists [9, 22-26]. For example, research by Hecker et al. [27] done on a large group of American family therapists showed that male therapists tended to pathologize their clients more often than female therapists, and highly religious male therapists tended to perceive male patients as more sexually addicted than female therapists did (regardless of their religiousness).

Gender and sex related issues are important not only in psychotherapeutic process but also in supervision. Research on family therapy supervisors and their trainees revealed characteristic patterns within gender-related conversational behaviors: male supervisors occurred to be highly directive [28] while female supervisors working with male therapists behave in a more collaborative and supportive manner [29]. In a system of male supervisor and female supervisee the quality of supervisors' collaborative behavior was lower, but in pairs of a female supervisor and a male therapist the engagement in teaching was lower as women engaged more in collaborative behaviors [30].

Another area of research connected with gender of therapist and supervisor concerns sexuality and personal boundaries. It occurred that the length of supervisors' professional experience increases their ability to discuss sexual fantasies and general sexual issues in supervision [31]. Another study showed that female and male supervisors differ in keeping personal boundaries: male supervisors accept sport activities with their trainees, for females supervisors this is unacceptable [32]. The same study showed that female supervisors are more sensitive to power issues. The relationship in supervision is connected with dependency and power so the emergence of issues related to gender is self-evident.

Research topics and premises described above show that gender issues in psychotherapy are very complex and common in all dimensions of this field: from detailed aspects of communication to begin with, to treating sex and gender as part of a broader socio–political discourse in psychotherapy.

Psychotherapy and gender issues and research in the Polish socio-cultural context

Gender analyses have been fully developed in Poland in many academic disciplines such as sociology, philosophy, cultural anthropology, literature, art history, but to a small extent have penetrated into the field of psychotherapy, even though there is a vast literature on sexual problems and psychotherapy [33, 34]. The reasons for this phenomenon are very complex. One possible explanations is that psychotherapy in our country is strongly rooted in medical discourse. Medical discourse causes the social and cultural perspective to remain in tension with the biological perspective which may be important when considering gender-related issues. Additionally, in medical environment we observe very hierarchical and patriarchal structure and relationships in comparison to other disciplines what also may hinder studies on the topic. It is also worth adding that the notion of "gender" in Poland is heavily immersed in the political and social context. In the recent years gender issues have become a bone of contention for the part of the Polish Catholic Church and conservative Catholic community. Some of the church representatives mention 'gender' in the context of homosexuality, transsexuality and pedophilia as an example of social pathology [35]. The situation of social tension and conflict that effectively prevents maintaining an objective research attitude does not encourage the study of gender issues. As a consequence, there are not many Polish research projects on gender issues in psychotherapy and the importance of those issues among Polish psychotherapists. This is a disadvantageous situation as it does not allow to compare how the issues researched and examined in other countries relate to and exist in the Polish cultural context. The present study attempts to fill this gap. The fact that this is one of the first studies of this type in Poland makes it exploratory and descriptive in its character.

The aim of the study

The study aimed to find out whether Polish psychotherapists, reflecting on their psychotherapeutic processes, identify their inner voices on gender and related roles. The following research questions were formulated:

1) Do Polish psychotherapists refer to their own gender-related experiences in the psychotherapeutic process and what, in their opinion, is their significance?
2) To what extent does patient's gender, attractiveness and the way they perform their gender roles disturb or facilitate a therapeutic process?
3) Do psychotherapists refer to their own experiences related to gender and gender roles in the supervision process and what, in their opinion, is their significance?

Method

In the first stage of the research, we used a survey constructed for the purpose of the pilot study. It consisted of 18 questions. Statistical analysis of 79 completed surveys prompted us to revise it and introduce certain changes. The second version consisted of 20 closed- and one open-ended questions.

Six research questions were formulated:

1. The what extent do psychotherapists refer to their own experiences as a girl/boy, daughter/son, woman/man, sister/brother, female partner/male partner, mother/father in the process of understanding a patient.
2. To what extent psychotherapists' own gender-related experiences are significant in the psychotherapeutic process in various forms of psychotherapy?
3. To what extent does the attractiveness of a female patient/male patient disturb the psychotherapeutic process?
4. To what extent does the attractiveness of a female patient/male patient facilitate and conduce the psychotherapeutic process?
5. To what extent does the approval/disapproval of the way in which a patient fulfils their gender roles (of a daughter/son, mother/father, female partner/male partner), disturb/facilitate the therapeutic process?
6. To what extent are sex- and gender-related issues introduced and raised by a psychotherapist in the supervision process?

The last open-ended question concerned family patterns and assumptions/scripts related to sex and gender issues in psychotherapist's family of origin. Due to the constraints of the present article, answers to the last question are subject to a separate paper.

Context of the research

Research was conducted during a Polish national conference for psychotherapists at which gender-related issues were the subject of one of the plenary sessions. The conference gathered therapists of many theoretical orientations, working with different groups of patients/clients at both public and private institutions, including private practice.

Statistical quantitative analysis

Continuous data were presented by means of the average value with standard deviation or by median with lower and upper quartile and minimum and maximum value when the analysis of a studied characteristics was based on non-parametric tests. Categorical data were presented as frequencies and percentages.

To compare means in two different populations t-test was applied or one of the alternatives, i.e. Mann-Whitney test (normality assumption not fulfilled) or Welch test (in case of heterogeneity of variance). Shapiro-Wilk test was used to assess agreement between empirical distribution of continuous feature with the normal distribution. Levene test was performed to verify the homogeneity of variance. To assess the relationship between two discrete features chi-square test or exact Fisher test was used.

The R software (v 3.3.1 www.r-project.com) was applied to all statistical calculations. The results with calculated p-value not greater than significance level α=.05 were considered as statistically significant.

Group description

144 people participated in the research; women constituted the majority of participants (No=100, 70% women; N=44, 30% men) which is consistent with the percentage gender distribution of Polish psychotherapists. The average age of the participants was 42.7 ±10.3 years. The youngest participant was 25 years old and the oldest one was 68 years old. Half of the participants (~70 persons) were 40 or less years old. 25% of the participants (~35 persons) were 36 or less years old, and 75% of the participants (~105 persons) were 49 or less years old. Figure 1 shows the number of persons and their age. It is clearly visible that the most numerous age group is the one between 30 and 40 years – 59 persons (41.3%). Table 1 summarizes the basic characteristics of the study participants.

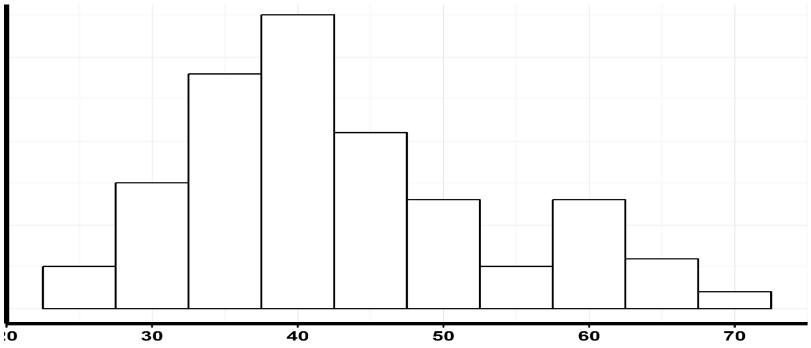

Figure 1. Histogram of age in whole studied group

Table 1. **Characteristics of the studied population (N=144)**

Feature	Description	Characteristics
Sex	Female Male No data	100 (69.4%) 42 (29.2%) 2 (1.4%)
Sexual orientation	Hetero Homo Bi Other	140 (97.9%) --- 2 (1.4%) 1 (.7%)
Psychological gender	The same as biological Different than biological Other[1] No data	138 (95.8%) --- 1 (.8%) 4 (3.4%)
Therapeutic approach	Psychodynamic Systemic Psychodynamic-systemic Integrative Other No data	23 (16.0%) 29 (20.1%) 32 (22.2%) 35 (24.3%) 13 (9.0%) 12 (8.3%)
Professional tenure	N mean ± SD Me (Q_1 – Q_3) min – max	129 14.4 ± 9.6 12 (8 – 19) 1 – 43
Psychotherapeutic certificate	Certified Psychotherapists Completed training, but no certificate yet Training to obtain certificate Does not train. No training to obtain certificate	57 (39.6%) 14 (9.7%) 57 (39.6%) 16 (11.1%)
Supervisory certificate	Certified supervisors Training to become supervisor None of the above	14 (9.7%) 9 (6.2%) 121 (84.0%)

Data presents the frequencies and percentages in case of categorical features, and mean, standard deviation (SD), median (Me), lower and upper quartile (Q1-Q3) and minimum and maximum value.

140 (97.9%) participants described themselves as heterosexual and considered their gender to be the same as their biological sex. Therapeutic approach used in their practice varied among the psychotherapists. Professional tenure ranged between 1 year and 48 years with an average of 14.4 ± 9.6 years. The study group was highly qualified: almost 40% of participants were certified psychotherapists and other 40% were in training to become one. Little less than 10% participants were certified psychotherapy supervisors and 6% were in the process of obtaining a supervisory certificate.

Statistical analyses were conducted taking into consideration all the above variables: age and sex of participants, professional tenure and practiced therapeutic approach.

[1] 60% same and 40% different

Results

Psychotherapists subjected to the research declared that in the process of understanding a patient they refer to their own experience as a girl/boy (G/B), daughter/son (D/S), woman/man (W/M), mother/father (M/F), female partner/male partner (FP/MP) to a large and middle extent (Table 2). Percentage differences indicate that therapists most often refer to their experiences as a woman/man, female partner/male partner and son/daughter. They use their own experience as a sister/brother (S/B) to a middle and small extent.

Table 2. **Frequency and percentages of answers to a question: To what extent a psychotherapist refers to her/his own experience as a girl/boy (G/B), daughter/son (D/S), woman/man (W/M), mother/father (M/F), sister/brother (S/B), female partner/male partner (FP/MP) in the process of understanding a patient**

	G/B	D/S	W/M	M/F	S/B	FP/MP
Large	41 (28.5%)	58 (40.3%)	74 (51.4%)	55 (38.2%)	30 (20.8%)	64 (44.4%)
Middle	54 (37.5%)	58 (40.3%)	56 (38.9%)	32 (22.2%)	49 (34.0%)	62 (43.1%)
Small	38 (26.4%)	23 (16.0%)	12 (8.3%)	11 (7.6%)	44 (30.6%)	13 (9.0%)
Not at all	1 (.7%)	1 (.7%)	---	10 (6.9%)	3 (2.1%)	1 (.7%)
Not applicable	1 (.7%)	---	---	29 (20.1%)	11 (7.6%)	---
No data	9 (6.2%)	4 (2.8%)	2 (1.4%)	7 (4.9%)	7 (4.9%)	4(2.8%)

abbrv.: G/B – girl/boy, D/S – daughter/son, W/M – woman/man, M/F - mother/father, S/B – sister/brother, FP/MP – female partner/male partner

The obtained results also show that psychotherapists refer to gender-related experiences during individual therapy (IT), couples therapy (CT), family therapy (FT) to a large and middle extent and to a lesser degree in group therapy (GT) (Table 3).

Table 3. **Frequency and percentages of answers to a question: to what extent a psychotherapist refers to her/his own gender experience during the individual therapy (IT), couples therapy (CT), family therapy (FT), group therapy (GT)**

	IT	CT	FT	GT	SUP
Large	49 (34.0%)	42 (29.4%)	31 (21.5%)	16 (11.1%)	14 (9.7%)
Middle	60 (41.7%)	52 (36.1%)	44 (30.6%)	36 (25.0%)	24 (16.7%)
Small	25 (17.4%)	14 (9.7%)	23 (16.0%)	23 (16.0%)	23 (16.0%)
Not at all	2 (1.4%)	2 (1.4%)	2 (1.4%)	4 (2.8%)	6 (4.2%)
Not applicable	3 (2.1%)	23 (16.0%)	26 (18.1%)	44 (30.6%)	55 (38.2%)
No data	5 (3.5%)	11 (7.6%)	18 (12.5%)	21 (14.6%)	22 (15.3%)

abbrv.: IT – individual therapy, CT – couples therapy, FT – family therapy, GT – group therapy, SUP – supervision

Based on the number of people in each age group, the participants were divided into those below 40 year old (N=64, 44.8%) and those older than 40 years (N=79, 55.2%).

This division into two groups was also substantiated by the differences in experience resulting from socio-cultural changes. Persons below 40 years, at the moment of the system

transformation, were children or were born already after 1989 what means that their adolescence and adulthood happened in the period of rapid and intense changes, on the one hand liberalizing social life and promoting gender equality, on the other advocating traditional values of neo-conservatism as a response to the liberal discourse. The group of people older than 40 years spent their adolescent and early adulthood in a culture characterized by patriarchal aspects overcome by the changes introduced by the communist system that in its ideology was blurring the differences between sexes.

The answers on the extent to which gender and gender-related issues are raised in the supervision process are puzzling. 38% of "not applicable" answers may indicate that the research subjects might have understood the question as addressed to supervisors only. It may also mean that gender-related experiences are not introduced in the supervision process. Due to the ambiguity of the question, the answers do not allow the researchers to appropriately interpret them.

Next, comparative analysis of all survey questions was run in all assessed groups. Table 4 shows the frequency and percentages of answers of the study subjects that significantly differed in age. Distribution of the answers to other questions did not significantly differed among the assessed groups and therefore were omitted in Table 4.

Table 4. **Statistically significant results of the comparison of answers to survey questions in the groups below and above 40 years old**

		age<40 (N=64)	age ≥ 40 (N=79)	P
To what extent do you refer to your experiences as a daughter/son in understanding of patients of both sexes	Large Middle Small Not at all Not applicable	32 (50.0%) 27 (42.2%) 4 (6.2%) 1 (1.6%) ---	26 (34.2%) 31 (40.8%) 19 (25.0%) 0 (0%) ---	.006
To what extent do you refer to your experiences as a mother/father in understanding of patients of both sexes	Large Middle Small Not at all Not applicable	25 (39.1%) 9 (14.1%) 3 (4.7%) 7 (10.9%) 20 (31.2%)	30 (41.1%) 23 (31.5%) 8 (11.0%) 3 (4.1%) 9 (12.3%)	.007
To what extent do you refer to your experiences as a female partner/male partner in understanding of patients of both sexes	Large Middle Small Not at all Not applicable	37 (57.8%) 24 (37.5%) 3 (4.7%) 0 (0%) ---	27 (35.5%) 38 (50.0%) 10 (13.2%) 1 (1.3%) ---	.024
To what extent do feelings of excitement/flirting that appear during the session disturb the process of therapy	Large Middle Small Not at all	9 (14.1%) 36 (56.2%) 18 (28.1%) 1 (1.6%)	5 (6.3%) 31 (39.2%) 36 (45.6%) 7 (8.9%)	.014

The results show that persons below 40 years of age to a larger extent refer to their own experiences as a daughter/son (p .006) and as a female partner/male partner (p .024) than

persons above 40 years old. Additionally, for this group of therapists feelings of excitement/flirting by a patient disturb the course of a therapeutic session to a larger extent than for therapists above 40 years old (p .014). Persons above 40 years old to a larger extent refer to their experiences as a mother/father (p .007).

With regards to the question of the extent to which attractiveness of a female patient disturbs/facilitates a therapeutic process (Pa-Z/Pa-S) and the extent to which attractiveness of a male patient disturbs/facilitates a therapeutic process (P-Z/P-S), the answers revealed statistically significant differences between sexes.

Table 5 shows distribution of the answers in the group of women and men to the questions that showed significant differences.

Table 5**. Selected results of comparing the answers to the questionnaire in the groups of women and man**

		Women (N=100)	Men (N=42)	P
To what extent does the attractiveness of a female patient disturb the therapeutic process	Large Middle Small Not at all	0 (0%) 14 (14.1%) 59 (59.6%) 26 (26.3%)	2 (4.8%) 21 (50.0%) 15 (35.7%) 4 (9.5%)	<.001
To what extent does the attractiveness of a male patient disturb the therapeutic process	Large Middle Small Not at all	6 (6%) 34 (34%) 54 (54%) 6 (6%)	0 (0%) 4 (9.5%) 22 (52.4%) 16 (38.1%)	<.001
To what extent does the attractiveness of a female patient facilitate the therapeutic process	Large Middle Small Not at all	3 (3%) 25 (25.3%) 57 (57.6%) 14 (14.1%)	2 (4.8%) 12 (28.6%) 21 (50.0%) 7 (16.7%)	.781
To what extent does the attractiveness of a male patient facilitate the therapeutic process	Large Middle Small Not at all	2 (2%) 34 (34%) 50 (50%) 14 (14%)	1 (2.4%) 5 (11.9%) 22 (52.4%) 14 (33.3%)	.007

Attractiveness of a patient of the opposite sex disturbs the therapeutic process in both assessed groups ($p < 001$). Attractiveness of a female patient did not turn out to be a significant factor that would improve the chances for a successful therapy (p=.781) run both by female as well as male psychotherapists. In the case of therapy run by female psychotherapists the attractiveness of a male patient improves chances of successful therapy (p=.007).

To sum up, psychotherapists' age and sex were found to be factors that significantly differentiated the study group (Table 6).

Table 6. **Age and gender and the triggering of inner voices in the psychotherapy**

Categories	Importance of therapist's own family role	Attractiveness of a patient of the opposite sex
female therapist below 40	Role of daughter/female partner	disturbing and facilitating
male therapist below 40	Role of son/male partner	disturbing
female therapist above 40	Role of mother	less disturbances/facilitating reported
male therapist above 40	Role of father	less disturbances/facilitating reported

Both in the groups of female and male therapists, the acceptance of the way in which patients fulfill gender roles facilitates the treatment to middle (K - 44.7%, M - 47%) or small extent (K - 38%, M - 37%). In this dimension sex did not significantly differentiate the obtained results.

Discussion

The results of the study indicate that Polish psychotherapists, during psychotherapy, activate their experiences and inner voices on gender and related roles in order to better understand patients they work with. This happens especially during individual, family and couples psychotherapy, where psychotherapists use their experiences particularly as a daughter / son, woman / man, mother / father, female partner / male partner, and to a lesser extent in group therapy. This result seems to be consistent with the specific character of each form of psychotherapy. The intensity of psychotherapeutic relationship in individual psychotherapy and in therapy of families and couples may trigger psychotherapist's own experience more often than the situation of group therapy, where the focus is on understanding the dynamics and the phase of the group process.

For therapists younger than 40 year old, their experiences as daughter/son and female partner/male partner in their own relationships were important sources of reference in the therapeutic work. Whereas, for therapist older than 40, their experiences related to the role of a mother/father were more significant. This result shows that personal experiences related to gender roles are used by psychotherapists in a way consistent with their age and stage of life cycle. One may wonder how much does activation of inner voices actually help a therapist in understanding a patient and to what extent it intensifies the counter-transference by identification or counter identification with the patient. As Bateson wrote [36], a difference is a piece of information which makes a difference, so when it brings new meaning, broadens perspective, piques curiosity. Cecchin wrote about this in a similar tone, [37, 38] emphasizing the importance of maintaining an attitude of curiosity by a psychotherapist on the one hand, and of questioning one's views and beliefs as factors relevant in psychotherapy process, on the other. The question arises how does triggering of voices of a psychotherapist's personal experience

influence the ability to maintain both of these positions: the curiosity and questioning of one's own beliefs. The obtained results show the direction for further research.

The results showed that the group of younger psychotherapists experience situations of flirting and excitation connected with a patient of the opposite sex as much more disturbing to the process of therapy. For younger female and male heterosexual psychotherapists working with opposite sex attractive patients is a challenge, which in case of male therapists disturbs the process of psychotherapy and in the case of female therapists may disturb or facilitate it. Understanding which aspects of attractiveness disturb or facilitate the process of psychotherapy requires a more in-depth research. The survey did not distinguish or ask to specify what patients' attractiveness means to therapists in a therapeutic relationship; whether that signifies interpersonal attractiveness or physical or sexual one. Therefore it poses some difficulty in interpreting the results. We may, for example, assume that the definitive assessment by male psychotherapists that attractiveness of female patients constitutes a factor disturbing the process of psychotherapy is connected with patients' physical and sexual attractiveness and expresses psychotherapists' urging fantasies. But it may also express better identification and acceptance of one's own inner voices related to urges and drives in comparison with the other groups.

This confirms the necessity of constant monitoring of issues connected with experiencing patients' attractiveness in the supervision and imposes on a supervisor the task of introducing questions about sexual fantasies into the supervision which should allow more open discussions on these aspects of a therapeutic relationship [32]. The findings confirm the significance of supervision due to counter-transference and importance of revealing inner personal voices. At the same time, they constitute a recommendation for a further research project that would allow to identify the content of these inner voices during a therapeutic session and would show how these co-construct the process of therapy. Examination of inner voices touches upon a very complex issue and simultaneously poses many methodological challenges. During a therapeutic session, a therapist tries to understand their own feelings which through that process become more conscious and organized. Then through expressing them out loud, these become even more organized but at the same time are no longer the same as thoughts and sensations [6]. Therefore the following question becomes very accurate: which research methods allow to get as close as possible to those thoughts and feelings. Procedures for examining inner voices, such as Dialogical Analysis [6, 7] or Interpersonal Process Recall [39] have their limitations in the form of de-remembering of sensations experienced during a session. As described by Rober et all [40] the understanding and hearing by a therapist his or her inner

voices is important to the process of therapy. This is especially vital in family and couples therapy. The analysis run by Blow, Timm & Cox [9] provides unambiguous proofs that family and couples therapies particularly activate gender-related experiences through projection of the expectations of family members onto therapists.

Practical conclusions drawn in the context of obtained results, apart from the above mentioned significance of supervision, indicate the need to raise the importance of the discussed issues among Polish psychotherapists. It seems vital not only to undertake detailed studies on the importance of sex and gender in psychotherapy but also to incorporate into the psychotherapeutic training program a module on gender issues that would include both theoretical topics as well as own experiences. Additionally, gender issues should be raised and discussed during psychotherapeutic conferences in Poland to a much larger degree than it has been done so far. These issues should be a subject of a deep reflection in psychotherapists' own work and in supervision.

There are limitations to the presented study. One of them is a relatively small number of psychotherapist subjects. Because 98% of the subjects defined themselves as heterosexuals, the results can only be referred to psychotherapists of this orientation. The research was based on a survey; psychotherapists showed that they are aware both of their inner voices related to gender and gender roles as well as using those in the process of understanding patients. In this sense, they shared their awareness of this process and declared the importance of these issues. Establishing the significance of gender issues is important but it is not the same as researching how in the process of a particular therapeutic session, inner voices of a psychotherapist get activated and describing how these co-create interactions between a psychotherapist and a patient and a psychotherapist and family members.

References

1. Stoller RJ. Sex and gender: The development of masculinity and femininity. Abingdon-on Thames: P: Taylor & Francis Group, 1994.
2. Butler J. Uwikłani w płeć. Warszawa: Wydawnictwo Krytyki Politycznej, 2008.
3. Stokoe EH. Gender and discourse, gender and categorization: current developments in language and gender research. Qual. Res. Psychol. 2004; 1: 107–129.
4. Hermans HJM. The dialogical self: between exchange and power. In: Hermans HJM, Dimaggio G, ed. The dialogical self in psychotherapy. Hove, New York: Brunner-Routledge; 2004, p. 13–28.
5. Hermans HJ, Gieser T, ed. Handbook of dialogical self theory. Cambridge: Cambridge University Press; 2011.
6. Rober P. The therapist's self in dialogical family therapy: Some ideas about not-knowing and the therapist's inner conversation. Fam. Process. 2005; 44: 477–495.
7. Rober P. Family therapy as a dialogue of living persons: a perspective inspired by Bakhtin, Voloshinov and Shotter. J. Marital Fam. Ther. 2005; 31: 385–397.
8. Artkoski T, Saarnio P. Therapist's gender and gender roles: impact on attitudes toward clients in substance abuse treatment. J. Add. 2013; ID 591521, http//dx.org.1155/2013/591521.

9. Blow AJ, Timm TM, Cox R. The role of the therapist in therapeutic change: does therapist gender matter? http://dx.doi.org/10.1080/0895280801907150
10. Johnson LA, Caldwell BE. Race, gender and therapist confidence: effects on satisfaction with therapeutic relationships in MFT. Am. J. Fam. Ther. 2011; 39: 307–324. 11. Jones EE, Zoppel CL. Impact of client and therapist gender on psychotherapy process and outcome. J. Consul. Clin. Psychol. 1982; 50; 2: 259–272.
12. Gehart DR, Lyle RR. Client experience of gender in therapeutic relationships: an interpretive ethnography. Fam. Proc. 2001; 40;4: 443–458.
13. Beutler LE, Brown MT, Crothers L, Booker K, Seabrook MK. The dilemma of factitious demographic distinctions in psychological research. J. Consul. Clin. Psychol.1996; 64: 892–902.
14. Schields CG, McDaniel SH. Process differences between male and female therapist in a first family interview. J. Marital Fam.Ther. 1992, https://www.researcggate.net/publication/229459197.
15. Anderson H. Conversation, language and possibilities: a postmodern approach to therapy. New York: Basic Books; 1997.
16. Werner-Wilson RJ, Zimmerman TS, Price SJ. Are goals and topics influenced by gender modality in the initial marriage and family sessions. J. Marital Fam. Ther. 1999; 25: 253–262.
17. Nelson ML. A current perspective on gender differences: implications for research in counseling. J. Consul. Psychol. 1993; 40: 200–209.
18. Bhati KS. Effect of client-therapist gender match on the therapeutic relationship: an exploratory analysis. Psychol. Rep. 2014; 115, 2: 565–585.
19. Wintersteen MB, Mensinger JL, Diamond GS. Do gender and racial differences between patients and therapist affect therapeutic alliance and treatment retention in adolescents? Profes. Psychol. Res. Pract. 2005; 36: 400–408.
20. Hatcher SL, Favorote TK, Hardy EA, Goode RL, Deshelter LA, Thomas RM. An analogue study therapist empathic process: working with difference. Psychother. Theor. Res. Pract. 2006: 42: 198–210.
21. Bowers AMV, Bieschke KJ. Psychologists' clinical evaluation and attitudes: an examination of the influence of gender and sexual orientation. Psychother. Theor. Res. Pract. 2005; 36: 97–103.
22. Sutherland O, LaMarre A, Rice C, Hardt L: Gendered patterns of interaction: a Foucauldian discourse analysis of couple therapy. Contem. Fam. Ther. 2016, DOI 10.1007/s10591-016-9394-6.
23. Avis JM. Feminist issues in family therapy. In: Piercy FP, Sprenkle DH, ed. Family therapy sourcebook, ed. 2. New York, London: The Guilford Press; 1996.
24. Avis JM. Pogłębianie świadomości: osobisty przewodnik po feminizmie i terapii rodzin. In: Braverman L, ed. Podstawy feministycznej terapii rodzin. Translation: Anna Tanalska-Dulęba. Gdańsk: Gdańskie Wydawnictwo Psychologiczne; 2003.
25. Jones E. Construction of gender in family therapy. In: Burck Ch, Speed B, ed. Gender, power and relations. London, New York: Routledge; 1995.
26. Braverman L, ed. Podstawy feministycznej terapii rodzin. Gdańsk: Gdańskie Wydawnictwo Psychologiczne; 2003.
27. Hecker LL, Trepper TS, Wetchler JS. Fontaine KL. The influence of therapist values, religiosity and gender in the initial assessment of sexual addiction by family therapists. Am. J. Fam. Ther.1995; 23(3): 261–272.
28. McHale E, Carr A. The effect of supervisor and trainee therapist gender on supervision discourse. J. Fam.Ther.1998;20: 395–411.
29. Moorhouse A, Carr A. A study of live supervisory phone-ins in family therapy: correlates of client co-operation. J. Marital Fam. Ther. 2001; 27: 241–250.
30. MoorhouseA, Carr A. Gender and conversational behaviour in family therapy and live supervision. J. Fam.Ther. 2002; 24: 46–56.
31. Heru AM, Strong DR, Price M, Recupero PR. Boundaries in psychotherapy supervision. Am. J. Psychother. 2004; 58(1): 76–89.
32. Heru AMD, Strong D. Price M, Recupero PR. Self-disclosure in psychotherapy supervisors: gender differences. Am. J. Psychother. 2006; 60(4):323–334.
33. Grabski B, Kasparek K. Dysfunkcje seksualne mężczyzn nieheteroseksualnych — analiza i krytyka piśmiennictwa. Psychiatr. Pol. 2017; 51(1): 85–94, DOI: https://doi.org/10.12740/PP/63768.
34. Grabski B, Kasparek K. Problemy seksualne u mężczyzn homo- i biseksualnych — omówienie

kontekstu zagadnienia. Psychiatr. Pol. 2017; 51(1): 75–83, DOI: https://doi.org/10.12740/ PP/61799.
35. Letkiewicz K. Obraz kobiety we współczesnym polskim Kościele rzymskokatolickim — na podstawie artykułów z Katolickiej Agencji Informacyjnej oraz wypowiedzi duchownych Kościoła katolickiego. http://feminoteka.pl/obraz-kobiety-we-wspolczesnym-polskim-koscielerzymskokatolickim, 22.12.2016.
36. Bateson G. Steps to an ecology of mind. New York: E. P. Dutton, 1972.
37. Cecchin G. Hypothesizing, circularity, neutrality revisited: an invitation to curiosity. Fam. Proc. 1987, 26(4): 405–441.
38. Cecchin G, Lane G, Ray WA. Irreverence a strategy for therapists' survival. London: Karnac; 1992
39. Elliott R, Shapiro DA. Brief structured recall: a more efficient method for studying significant events. Brit. J. Med. Psychol. 1988; 61: 141–153.
40. Rober P, Seikkula J, Latila A. Dialogical analysis of storytelling in the family therapeutic encounter. Hum. Syst. J. Ther. Consult. Training, 2010; 21: 27–49.

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