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Social Workers' Perspectives on Sexuality in Social Work Practice

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Social Workers' Perspectives on Sexuality in Social Work Practice

by

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Abstract

Sexuality has been underexplored by social work scholars. To help address gaps in this area, I studied social workers' perspectives on various aspects of sexuality in my thesis research. I used qualitative, feminist methodology because of the fit with the topic area and research questions. The sample of 14 social workers participated in semi-structured interviews. Thematic Analysis indicated that the participants were predominantly comfortable with sexuality-related topics. Generally, they disclosed acceptance of their own sexuality and had sought additional related education. The participants agreed that social work educators should increase curriculum on sexuality but recognized some of the constraints involved. Overall, the participants considered capacity to address sexuality-related topics in therapeutic conversations a key aspect of competent practice and identified several tools for that purpose. These findings have implications for social work generally, and for aspects of practice, education and research specifically.

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Disclosure: This thesis has been professionally edited.

For all the sex happening in the margins

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Chapter One: Introduction

> *What is counselling? It's an awfully funny thing, isn't it? Our culture, our society, people, employers, clients invite me to step into their life, ask intimate details, share things with me, and hopefully I have enough professional expertise, life experience, common sense, and the whole range of stuff that I can provide something useful. A model is not what that's about. A model is not what that's about. (Ian, study participant)*

Even the most reflective, skilled, and experienced social workers occasionally experience discomfort discussing sensitive issues within a therapeutic context. Sexuality, a multifaceted and complex area critical to human life, is likely among these discomfiting topics and involves biological, psychological and cultural factors that influence such life events as reproduction, eroticism, and desire. Social work occurs within and reflects the larger social context wherein discussions of sexuality have long been viewed as taboo (Askew 2007; Henry, 2013; McEntarfer, Skiba, & Robert, 2012; Roberts, 1986; Tennille, Solomon, & Bohrman, 2014; Timmerman, 2001). In this context, repressive and sexist norms have remained relatively unchallenged, contributing to what many now refer to as a heteronormative culture. Given that social work education gives little attention to practice in the area of sexuality (McCave, Sheperd, & Winter, 2014), clinicians' interactions with clients in this area are at risk of reflecting and perpetuating heteronormative norms and assumptions.

Social work clinicians' attitudes towards sexuality vary, as do their practice experiences and comfort levels, which in turn effects their ability to meaningfully incorporate the important topic of sexuality in practice (Gill & Hough, 2007). The

general purpose of this study is to contribute to the empirical base regarding this relatively scantily investigated topic area within the discipline of social work. The study was designed to develop a greater understanding of social workers' attitudes and experiences in engaging their clients in discussions of sexuality in a therapeutic context.

Sexuality is an important component of human life and development. Sexuality changes and develops over time; and throughout life individuals have various experiences of sexuality, both positive and negative. In addition to reproductive and sexual health around conception and birth and throughout puberty and sexual maturity, some people also experience adverse sexual health events such as child sexual abuse, date rape or sexual assault and violence, reproductive or sexual dysfunction, or identity issues, and all of these aspects constitute parts of sexuality. Helping professions (nursing, psychology, social work) seem to agree that there is a need to consider sexuality as an integral part of human experience given its contribution to emotional, psychological, cognitive, and social well-being (Auteri, 2015).

Social workers in particular may regard sexuality as an integral part of functioning as these professionals provide services to some of society's most marginalized individuals, families, and communities. Within the realm of sexuality in general, social workers may work closely with clients who have been victimized by sexual violence and abuse, are struggling with sexual identity issues, or are trying to cope with atypical and sometimes criminal sexual interests. However (and as to be discussed further in Chapter Two, the review of literature), there is some evidence that few social workers and health care clinicians broach the topic of sex with clients (Dyer & das Nair, 2013), and clients may feel reticent to discuss their sexual challenges of their own accord.

Bancroft (2009) asserted that clinicians do not feel comfortable talking to their patients about sex; Pukall (2009) echoed this sentiment, claiming that not all therapists are good at sex therapy because not all therapists are good at talking about sex, while Tomlinson (1999) claimed that neither clinician nor client feels comfortable addressing this topic.

Researchers focus on particular problem areas for different reasons (Creswell, 2014). For this project, I identified the research problem based on personal and professional experiences and after encountering the obvious gaps in the theoretical and empirical literature. While researchers in other fields and disciplines have examined sexuality thoroughly (Parker, 2009), social work has not made research on this topic a priority. Consequently, social work specific literature in this field is limited, and professionals must borrow from allied fields such as nursing and psychology to develop clinical competencies in this area. Social work has a history of relying on research and theory from other helping professions, which is not, in itself, a problem, particularly given the profession's aim of interdisciplinary cooperation. However, unique aspects of social work—including attention to the person in her or his environment and scrutiny of structural and cultural factors—are often not incorporated in literature from other helping fields. Thus, the need for social work-specific research and literature related to sexuality is undeniable.

The purpose of this research study, using qualitative, feminist methodology and Thematic Analysis, was to understand and explore the perceptions and attitudes of social workers regarding discussions of sexuality with their clients, as well as what they believe may contribute to their attitudes. Using individual interviews with social workers, I explored the barriers to discussing sex, as well as the circumstances in which social

workers feel comfortable exploring sex-related topics with clients. My hope was to gain understanding from practical experiences of social workers, their education, and personal backgrounds, in order to better prepare social work practitioners to address the sexual health needs of their clients. This exploratory research is well suited to a qualitative approach as it addresses a rarely analyzed area in which the participants are invited to uncover rich dimensions of personal truth and experience.

The results of this exploration of perspectives on and attitudes towards sexuality will be of interest to social workers for a variety of reasons. This topic area has seldom been empirically investigated in social work scholarship (McCave, Shepard, & Winter, 2014; Trotter, Crawley, Duggan, Foster, & Levie, 2009). When social work literature has concerned itself with sexuality, it has been either within a narrow heteronormative framework or a negative context (Jeyasingham, 2008). The profession's mandate to address issues of marginalization and oppression and to advocate for social justice underscores the importance of widening the discourse on this topic. I hope the results of this study will support social workers, across all fields and levels of practice, to reflect upon and evaluate their own attitudes regarding sexuality and the factors that influence these attitudes. This study may also be beneficial to the fields of sexology, sex therapy, family and marital therapy, and psychology as there are significant overlaps and similarities between social work and these fields. Faculty members within universities hosting and developing social work programs may be interested in exploring how they can train and nurture their social work graduates to be competent in this area. Such developments could contribute to graduating more well-rounded and skilled professionals.

This thesis follows the traditional chapter progression of literature review, methods, results, and discussion. In Chapter Two, I provide a comprehensive literature review which first defines concepts related to sexuality and documents the rationale and need for the current study. Chapter Three provides a discussion of the methodology that outlines the foundation for the specific method used in the study. The methods (participants and procedures) are then described. A description of the approach to the analysis is provided at the outset of Chapter Four, followed by a discussion of the study results. Finally, Chapter Five offers discussion, linkages to extant literature, limitations, and recommendations regarding social work practice applications and future research.

Chapter Two: Review of the Literature: Sexuality and Social Work

Within the helping professions, the topic of sexuality is important as a result of the central role of sexual identity in people's lives, the importance of sexuality within intimate partnerships, and the prevalence of problems that have an impact on sexual health. It is well recognized that effective and ethical social work entails a holistic approach (Coady & Lehman, 2008; Craig & du Preez, 2004; Ruch, 2002), with sexuality as a critical aspect of intra- and inter-personal functioning (Buehler, 2014; Dunk-West, Hafford-Letchfield, & Quinney, 2009; Gray, House, & Eicken, 1996; McCave, Shepard, & Winter, 2014; Satterly & Dyson, 1998). In particular, recent studies indicate that clients in social work practice settings often present with issues related to sexuality; these include, for example, within health and mental health (Davison & Huntington, 2010), sexuality and disability (Friedman, Arnold, Owen, & Sandman, 2014; Kattari, 2014), sexual violence (Gavey & Senn, 2014; Martin, Macy, & Young, 2011; Zoldbrod, 2015), and sexuality across the life span (Schwartz, Diefendorf, & McGlynn-Wright, 2014).

Despite the relevance of sexuality in clinical practice, recent literature suggests that helping professionals, including social workers, are often reticent regarding the topic. There is evidence that proportionally few clinicians actively engage clients in discussions regarding sex or sexuality (Bancroft, 2009; Dunn & Abulu, 2010; Magnan & Reynolds, 2006; Moreira, Brock, Glasser, Nicolosi, & Laumann, 2005; Trotter et al., 2011). At the same time, however, empirical evidence supports the assertion that, for many clients, sex and sexuality are clinical priorities (Anderson, 2013; Balon & Segraves, 2005). This gives credence to Dunk-West and Hafford-Letchfield's (2011) assertion that, because sexuality is an inherent human phenomenon, the "sexual self" must be considered an

inseparable aspect of the client's identity.

The reticence of clinicians to engage in sex-related topics with clients may reflect a variety of factors. While social work has always been concerned with the most sensitive of topics of human experience (e.g., criminality, bereavement, mental illness), clinicians seem to be consistently less prepared for practice when the sensitive topic is sexuality. There is evidence that social work degree programs include limited sexuality-related content (Fredrikson-Goldsen, Woodford, Luke & Gutierrez, 2011; Laverman & Skiba, 2012; Logie, Bridge, & Bridge, 2007; McInroy, Craig, & Austin, 2014; Pelts, Rolbieki & Albright, 2014; Pukall, 2009; Satterly & Dyson, 1998; Trotter et al., 2011). The lack of sexuality education may start earlier than social work education; researchers have critiqued the limitations of sexual education in the wider education system as well as within the human services (Craig & du Preez, 2004; Hanzlik & Gaubatz, 2012; Laverman & Skiba, 2012; Roberts, 1986; Tepper, 2000; Ward, 2016).

Skill and knowledge deficits may leave social workers ill-prepared to address clients' sexuality-related concerns. Sehl (1998) suggested that social workers who feel shame or guilt related to their own sexuality will be ill-equipped to effectively manage sexual topics in psychotherapy, perhaps negating or avoiding content that makes them uncomfortable but may be central to the client's story. Increasing self-awareness through reflective practice can foster the practitioner's comfort and competence in specific topic areas, which likely includes sex and sexuality, and is imperative in the value-driven field of social work (Mallon, 2009). Conversely, effective clinical work may be less likely if the clinician has not considered her or his own values and beliefs about, and (possibly problematic) experiences with, sex and sexuality. Thus, given the potential for negative

cultural, educational, and personal experiences, it is not surprising that social workers could experience interactions with clients regarding sexuality as overly personal, sensitive, and uncomfortable. Ultimately, the effectiveness of services to clients may be compromised (Holley, Tavassoli, & Stromwell, 2016; Swislow, 2015).

In summary, there is general consensus across the helping professions that sexuality is a key component of life that may be influenced by a variety of experiences. At the same time, there is evidence that practitioners are often hesitant to address sex-related issues and post-secondary social work programs provide few opportunities for skill and knowledge development about sexuality. This combination of factors provides the rationale for the current research, which explores the following research questions:

1. What are social workers' perceptions and attitudes regarding discussions of sexuality with clients?
2. What are social workers' practical experiences, education, and personal backgrounds in relation to therapeutic conversations about sexuality and sexual health? and
3. What are social workers' perceptions of the barriers to discussing sexuality and the circumstances in which they feel comfortable exploring this topic with clients?

In the following review, I consider literature on key aspects of the research questions. Following a brief section on the process I followed for the literature search, I provide an overview of the history of sexuality and its key influencers. I then identify and define key terms in the field of sexuality for the purpose of this research. The importance of sexuality in social work practice is addressed in the fourth section, which includes a discussion of the social work mandate and sexuality implications within fields of social work practice. I then discuss some lessons learned from allied helping

professionals in sexual health work before moving on to a thorough discussion of the theoretical approaches to helping in sexuality. In the conclusion, I reflect on what the literature review indicated regarding facilitators and constraints potentially experienced by social workers relative to therapeutic conversations involving sexuality.

Situating Key Constructs

In this section of the review, my intent is to provide context for and an overview of some of the key constructs related to sexuality by offering a synopsis of the history of thinking about sexuality while identifying some of the central contributors to the field historically. Important terms will be defined in this overview, but given that the sexuality field seems to be in constant flux, these definitions are best understood as rather fluid and malleable.

Literature retrieval: Criteria and search strategies. To retrieve literature for this review, I used the University of Calgary Library online database with specific attention to PsychInfo, Social Sciences, and Taylor and Francis journal databases. A set of particularly relevant journals were also hand-searched for more information. These included the *Journal of Human Sexuality*, *Social Work and Society, Social Work Education, American Journal of Sexuality Education, Journal of Women and Social Work, Advances in Social Work*, and the *Journal of Psychology and Human Sexuality*. Specific search terms combined "social work" with sub-field specific words including "sexuality," "sexual health," and "sex therapy." Based on the limited number of results returned on the initial search, additional terms were added including: "mental health" and "social sciences," "attitudes," and "comfort." Other resources were added rather intuitively through examination of articles' reference lists. Items were included in the

review based on their discussion of topics/sub-topics they could potentially illuminate. Recent scholarly contributions to the field (especially from the 1990s onwards) were given relatively more attention than more dated works.

As discussed in more detail below, a period of increased interest in sexuality education and research in social work during the 1960s and 1970s was followed by a decline in interest which continues today. That is, while the occasional research or theoretical article, book, or special edition of an academic journal appears, "sexuality in social work" or "sexuality in social work education" have received little sustained attention in recent academic literature. Due to the scarcity of social work specific literature, I included contributions from other helping and health professions (nursing, counselling psychology, and mental health counseling) in my search. It is not unusual for social work professionals and academics to draw on literature from other disciplines that share similar concerns and theoretical perspectives. This can be considered a strength within social work as it contributes to and reflects cross-disciplinary collaboration. At the same time, it is important to not lose track of social work's unique perspective and value base (Meinert, Pardeck, & Kreuger, 2000; Trevithick, 2008). I also drew from broader disciplinary bases including psychology, sociology, and medicine. Furthermore, since sexuality and sexual counselling (or sex therapy) are considered unique areas of specialization, literature from these sources was also considered.

Sexuality: A brief history. Understanding the history of sexuality as a field of inquiry is important in part because both clients and practitioners may continue to be influenced by discourses that, while perhaps now recognized as being of questionable validity and helpfulness, continue to be given credence in public discussions of the topic.

The field of sexuality seems to evolve at an astonishing pace; as Jackson and Scott (2010) explained, "since sexual relations and practices are embedded in the social, it follows that they are subject to change, rather than being fixed by 'nature,' and cannot be expected to remain constant over time and place" (p. 50).

In the Western world, the roots of what we now think of as "sexuality" can be traced back from the ancient Greeks and Romans through the period of the European Middle Ages. During these millennia, understandings of sexuality-related problems tended to be attributed to supernatural and/or religious explanations (Berry, 2013a, 2013b; Bullough, 2001). While psychological and medical perspectives on sexuality and concerns related to sexual intimacy began to appear in the early 18th century, what we now characterize as the "scientific study" of sexuality had its real beginnings in the late 19th and early 20th centuries (Berry, 2013a; Bullough, 2001). Authors in the field of sexuality have taken a variety of approaches to characterize the field's development. Berry (2013a), for example, highlighted the influence of different disciplines over time. Taking a sexuality education perspective, Jones (2011) distinguished 28 discourses regarding sexuality that she categorizes as conservative, liberal, critical, or postmodern. Atwood and Klucinec (2007) presented their "socio-history of sexual theory and therapy" through six paradigm shifts evolving over time since the Middle Ages. Because this framework seems to be compatible with social work's commitment to considering assumptions' underlying lenses, I have used it to help frame my discussion of the history of sexuality. At the same time, like any such framework, the paradigm framework conceptualized by Atwood and Klucinec—and my summary of it—likely oversimplifies and overgeneralizes complex developments.

In the first paradigm shift, Atwood and Klucinec (2007) described "the rise of the medical professions" (p. 59), integral to the shift away from religiously-dictated explanations that had previously been dominant. The field of sexology emerged in this "early period," initially in Europe in the mid-19th century and quickly spreading to North America. The early mission of the field of sexology has been described as an "attempt to transfer authority for explaining sexual matters from the church and the legislative-juridical realm . . . to psychiatry and medical science" (Moddelmog, 2014, p. 269). There was increasing public attention on sexual health issues including prostitution, masturbation, and birth control, and the field of sexology sought to address and challenge traditional Victorian values around sex (Irvine, 1998; Moddelmog, 2014). Among the leaders in the creation of sexology was Austro-German physician, Richard von Krafft-Ebing (1840–1902) who argued that people with "sexual perversions" were morally, mentally, and physiologically sick, and that these individuals were a threat to society. The early focus of the field on typologizing sexual behaviours, which contributed to pathologizing behaviours and practices considered outside "normal," continues to echo in current usage of categories such as "homosexual, masochist, fetishist, transvestite, and sadist" (Moddelmog, 2014, p. 269).

Historically, sexology has privileged reproductive behavior wherein "penetration is the cornerstone of sexuality" (Downing, 2015, p. 1142). Havelock Ellis (1859–1939), another early sexologist, wrote extensively on the topics of sexuality, eugenics, and homosexuality. Approaching human sexual health with positivity, Ellis was open, accepting, and tolerant of sexual practices and challenged the Victorian values of the era. He may have been ahead of his time, advocating a biopsychosocial model of the

treatment of sexual dysfunction (Berry, 2014).

A key enduring influence from what Atwood and Klucinec (2007) called "the early years" of sexuality is the work of psychoanalyst Sigmund Freud (1856–1939). Whether Freud was indeed a sexologist has been debated (Moddelmog, 2014) but his influence extends beyond psychoanalysis to popular culture. His focus was not on pathologizing sexual health issues and was opposed to demonizing those who exhibited sexual perversions. In opposing the view that perversions created degenerates, he became one of the first critics of sexology (Downing, 2015). According to Freud, libido and sexuality are the driving forces in human psyche and he emphasized the related concepts of erotic transference, the Oedipus complex, and hysteria (Krohn & Krohn, 1982). Feminist scholars have highlighted and rejected Freud's oppressive gender assumptions, asserting his theories are biased and sexist (Laidlaw & Malmo, 1991; Nolan & O'Mahony, 1987). Freud's theories about gender and sexual motivation are widely criticized today, but what seems to remain of Freud's influence (at least for some practitioners) is his focus on a talking cure, which, in his time, included years of psychoanalysis designed to create sexual health through eliminating neurosis (Buehler, 2014; Southern & Cade, 2011; Vaughn, 2009).

The shift to sexuality's "middle years" according to Atwood and Klucinec (2007), was largely attributable to the rise of empirical research, which, in the sexuality field, focused on establishing and codifying "normal" sexual behavior. An influential figure during this time was Alfred Kinsey (1894–1956), who, although initially trained as a zoologist, came to be regarded as the grandfather of the sexual revolution. "When Kinsey reported on the heterogeneity of sexual conduct in America, Americans who had

previously felt deviant gave a collective sigh of relief" (Hart & Wellings, 2002, p. 898). Kinsey's research has since been criticized on methodological grounds. However, it was extensive, involving interviews with over 10,000 women and men in the U.S. (Atwood & Klucinec, 2007). The results radically changed perceptions as Kinsey's endeavor to categorize sexual behavior revealed wide diversity. The development of the *Kinsey Scale* of homosexuality (from 0 - heterosexual to 6 - homosexual) was important in demonstrating the frequency with which "everyday" people engaged in what had previously been considered deviant sexual behaviours. Famously sex-positive, Kinsey stated: "The only unnatural sex act is that which you cannot perform" and one of his main goals in conducting sex research was to promote acceptance for non-normative sexual behaviors (Buehler, 2014; Corber, 2005; Drucker, 2010). His notable works include *Sexual Behavior in the Human Male* (1948) and *Sexual Behavior in the Human Female* (1953).

Also key during this "middle period" of the development of the field of sexuality was the work of William Masters and Virginia Johnson during the 1960s and early 1970s. Moving away from Kinsey's interview methodology, Masters and Johnson used laboratory observations, through which they developed the model of the "human sexual response cycle." Understanding sexual response as moving through "excitement, plateau, orgasm, and resolution" was a significant contribution to the field, which was further amended and challenged by their psychodynamically focused contemporary, Helen Kaplan, who proposed alterations and a model that incorporates the phases of "desire, arousal, and orgasm" (Buehler, 2014). Nevertheless, Masters' and Johnson's contributions to the field may be unparalleled in that they defined human sexual behavior

and response, and developed treatment methods including "Sensate Focus." Masters and Johnson are regarded now as folk heroes, maintaining their place in popular culture with a new television program based on their lives and work.

Rather than psychoanalysis (Freud's lengthy "talking cure"), Masters and Johnson advocated behavioral therapy and homework of prescribed activities. These activities, such as "Sensate Focus," were designed to reduce symptoms, and Masters and Johnson maintained a non-pathological approach to their work in the area of sexual health (Beuhler, 2014). They left room for physiological and also psychosocial factors in their evaluation of the cause of sexual dysfunction (Binik & Meana, 2009).

Atwood and Klucinec (2007) denoted the third paradigm shift in our understanding of sexuality as "the shift to the social" (p. 63). Key in this period—during the 1970s and 1980s—was the movement away from biologically-based theories to understanding sexuality and human sexual behavior as socially constructed. Jackson and Scott (2010) further explained that this period was one that romanticized love and emphasized good sex as fundamental to relationships. Sex was no longer reserved for procreation, but instead tied to fulfillment and pleasure (Jackson & Scott, 2010).

A fourth paradigm shift in our understanding of sexuality occurred, according to Atwood and Klucinec (2007), when the "historical" was "added" to the social predominantly through the work of Michel Foucault in the late 1980s and early 1990s. Foucault's critical perspective included the anti-essentialist and anti-universalist perspectives that, respectively, sexuality only exists through its social creation and is a product of history (Jackson & Scott, 2010). Foucault conceptualized the socially produced "discourses" that, with respect to sexuality, contribute to how sex and sexuality

are policed and monitored, and how we contribute to that regulating ourselves (Jones, 2011; Petit & Hegarty, 2014). Foucault did not consider himself to be a postmodernist, but is widely described in this way (Jackson & Scott, 2010). He also did not concern himself in any large way with feminism and gender, but nonetheless his ideas and influence have been taken up by feminists and provided significant impact on queer theory. Despite his influence, a major feminist critique of Foucault's writings on sexuality is his conflation of gender and sexuality as well as his approach to power, which he theorized as being both institutionalized and distributed (Jackson & Scott, 2010). Foucault remains a powerful influence on the discourses related to and our understanding of sexuality, and it is therefore important that some mention of his work be included in a thesis project of this nature.

For Atwood and Klucinec (2007) "the feminist influence" heralded the fifth paradigm shift in the understanding of sexuality. Atwood and Klucinec's point seems mainly to be that, during the late 1980s and into the 1990s, feminists drew attention to the gender imbalance in the scientific study of sexuality and its growing knowledge base. Feminists critiqued science for creating/perpetuating the idea of normal: heterosexual, middle/upper class males with a *healthy* sexual appetite able to give "'healthy' penetrative orgasmic sexual pleasure to a doting monogamous sexual partner" (Atwood & Klucinec, 2007, p. 65). Jackson and Scott (2010) theorized that the social construction of gender serves to maintain the oppression of women through capitalism and patriarchy, and is reinforced through sexual violence and coercion as well as the institutionalization of heterosexuality.

The final paradigm shift, according to Atwood and Klucinec (2007), moved us

into the postmodern and current understanding of human sexuality. While Foucault's direct work on sexuality is not featured here, his analytical methods have been fairly dominant within the critical theory of this period (Jackson & Scott, 2010; Tolman & Diamond, 2014). In postmodernity, sexuality is regarded as unfixed and flexible, viewed as contingent upon place, time, and social institutions rather than as a thing one possesses or exhibits (Tolman & Diamond, 2014). Jeyasingham (2014) used a postmodern perspective to discuss sexuality within anti-oppressive practice in an effort to reveal the underlying constructs that influence different conceptualizations of sexuality across anti-oppressive texts. According to Jeyasingham, sexuality is often related to desire and pleasure but could also be understood as an aspect of intimate and personal identity, and influenced by context and culture (Jeyasingham, 2014). Tolman and Diamond (2014) expanded on this postmodern understanding by contending that sexuality is contextualized by the creation of meaning, language, and social forces that are often invisible to the people they influence.

As this discussion indicates, in a relatively short period—just over a century—approaches to understanding sexuality have undergone several shifts. While scholars and researchers may be able to identify the postmodern assumptions of their work (Jeyasingham, 2014), less contemporary notions and attitudes may remain among both professionals and the public generally. Situated within the postmodern era, the discussion of definitions of sexuality and related concepts I review in the next section can be understood as evolving rather than fixed, as working definitions that are "dynamic and subject to modifications over time as our conceptualizations change" (George, Norris, Nguyen, Master, & Davis, 2014, p. 656).

Sexuality and sexual health. It is now widely accepted that sexuality—and the discussion thereof—is influenced by multiple factors including biology, psychology, and culture (Verschuren, Enzlin, Dijksta, Geertzen & Dekker, 2010; World Health Organization, 2010). Human sexuality understood in contemporary times is broad, complex, and multifaceted. Nyanzi's (2006) definition of sexuality demonstrates this complexity:

> Rather than conceptualising sexuality as merely situated in the body and bodily functions, consideration of the range of meanings that individuals and groups attach to it is critical. Such a nuanced definition should embrace: desire, the erotic, emotions, sensuality, fantasy, intimacy, commitment, power, relationship, negotiation, exploration, exploitation, expression, trust, personhood, belonging, identity, pleasure, entertainment, consumption, obligation, transaction, dependence, work, income, resistance, abuse, masculine entitlement, feminine propriety, respectability, spirituality, custom, ritual, and more. These factors touch on gender, race, class, citizenship, community, and religion. The hallmark of sexuality is its complexity—its multiple meanings, sensations, and connections. (p. 1852)

While Nyanzi's definition is complex and multifaceted, the most widely accepted and perhaps better known definition of sexuality is given by the World Health Organization (WHO), who consider sexuality

> a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies,

> desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors. (2016, ¶6)

With the multifaceted definitions of sexuality in mind, it is important to reflect on the genesis of the terms sexuality and sexual health. Edwards and Coleman (2004) described the evolution of the term "sexual health" between 1975 and 2002. Briefly, according to these authors, the definition moved from one that reflected a desire to have a scientific truth to one that reflected the influence of always-evolving culture and values. Edwards and Coleman (2004) claimed that in creating a definition for sexual health, categories of normal or abnormal are reified and perpetuated. Some conceptualizations of sexual health continue to reflect a biomedical orientation—for example, according to Verschuren et al. (2010), "sexuality is a phenomenon in which biological and psychological factors interact, so both a person's physical condition and his or her psychological well-being represent interdependent cornerstones of sexual health" (p. 156). The World Health Organization has defined sexual health more broadly as:

> a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. 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. For sexual health to be attained and maintained, the sexual rights of all persons must be respected,

protected and fulfilled. (2010, p. ¶4)

Although still debated and criticized, the WHO definitions are currently the "most widely accepted and enduring" (George et al., 2014, p. 655). George and colleagues emphasized the importance of recognizing the potential for ongoing modifications of the definition, anticipating that conceptualizations of sexual health have and will continue to evolve. What seems to be clear throughout the definitions of sexual health—within the World Health Organization, the World Association of Sexology, Planned Parenthood, and for many sexologists, educators, and scholars—is that sexuality and sexual health are integral parts of human well-being (Auteri, 2015).

Sexual orientation and sexual identity. Sexual orientation refers to attraction toward and experiences of sexuality in relation to partners of the same sex, opposite sex, or both. Broad labels of sexual orientation include homosexual, heterosexual, pansexual, bisexual, asexual, and questioning. Sexual orientation may at times be confused with sexual identity, a distinct umbrella term that "includes attitudes, perceptions, beliefs, and images that create an internal sense of our sexuality, which ultimately directs our behaviour" (Burlew & Capuzzi, 2010, p. 7).

Until fairly recently, both sexual identity and sexual orientation were thought to be essential to identity—that is, fixed in biology. Assumptions can be made about a person's sexual identity regardless of the label to which the individual ascribes, for instance assuming the label "gay" based on stereotypical behavior. Sexual identity encompasses gender identity as well as orientation.

Gender. Gender refers to the social constructions, characteristics, representations, and norms associated with being masculine or feminine, male or female,

both or neither (Gender, Equity, and Human Rights, 2016). Sex is typically ascribed at birth and fixed in biology according to the genitals observed at the time, whereas gender identity is related to how one sees their innermost sexual concept. While gender is increasingly understood as fluid, society has a long way to go to embrace the needs and provide respect for trans individuals—people assigned one gender but who self-identify differently. Recent debate over gender neutral and trans public restrooms has displayed the widespread mistreatment and marginalization of these groups. It is estimated that about one in 333 people worldwide is transgendered and may struggle with transphobia (discrimination based on gender identity), intersecting with homophobia, sexism, and misogyny (Gates, 2011). Other important terms related to gender identity are cissexism and cisnormativity, which are concepts related to sexism and heteronormativity in which cisgendered individuals (those who identify with their birth gender) are privileged above trans individuals and trangenderism is delegitimized. One way in which discrimination is demonstrated is by misgendering and mispronouning trans individuals (Erickson-Schroth, 2014).

Heteronormativity. Heteronormativity refers to the discourse that promotes traditional or mainstream sexual orientation and practices as "normal," resulting in the marginalizing or "*othering*" of differences from the heterosexual standard. According to Eaton and Matalama (2014), heteronormativity is inextricably linked to gender roles that promote and maintain a hierarchical difference between men and women. According to these authors, "heteronormative beliefs should be understood and represented as an underlying concept that motivates most, if not all, measures of heterosexual sexuality and gender relations" (p. 1445).

Although use of the term "heteronormativity" appears relatively recent, feminist scholars have expounded upon the links between compulsive heterosexuality, gender roles, and equality for years (Knight, Shoveller, Oliffe, Gilbert & Goldenberg, 2013; Ward & Schneider, 2009). The heteronormative discourse influences ideas and beliefs about sexuality but also more broadly about gender roles and reproduction, placing value on some expressions of sexuality while pathologizing others (Downing, 2015; Habarth, 2008; Jeyashingham, 2008; Knight et al., 2013; Ward & Schneider, 2009). Heteronormativity operates like a clandestine force, perpetuated by social institutions that privilege and benefit those who fit within heterosexual ideals (e.g., marriage). A normative value judgement, this discourse has been influential in all fields but perhaps especially within sexology and psychiatry (Downing, 2015).

One of the by-products of heteronormativity is socialization into gender roles that are culturally bound and reflect double standards and sexual disparities. Women and trans individuals are expected to live in an androcentric (focused on or dominated by men), patriarchal (male-power led) world that relegates them to the status of second-class citizens and presumed inferior, the product of being socialized into these experiences (Jackson, 2010), wherein one group is privileged at the expense of others (Sewpaul, 2013). Society continues to struggle to see women as capable of holding positions of power and leadership, based simply on their gender and, at times, race (Sewpaul, 2013). The sexuality of women and girls is constructed not as a stand-alone quality, but only in relation to male sexuality; women function without their own sexual agency. Females are assumed to have no sexual desire, but instead are passive participants in the desire of the voracious male libido (Bay-Cheng & Lewis, 2006; Holland, Ramazanoglu, Sharpe, &

Thomson, 1999; Morokoff, 2000; Phillips, 2000). The expectation is that girls are to be desirable, but not desiring, and sexual looking but not sexual acting, and are pressured to fill the role of "good girl," complying and deferring to others (Bay-Cheng & Lewis, 2006).

Heteronormativity can be reinforced through various social structures including religion and the media. Regarding the influence of religion on defining "normality," Foucault (1978) contended that sexuality has long been constructed and understood through religion, which dictates appropriate and inappropriate sexual behavior as "right" or "sinful." Sex after marriage is right, if used as a tool for procreating, but sex between two men is wrong, and the same holds true for sex before marriage. Lower sexual risk-taking behaviors are known to be connected to religiosity (Murry, 1997) and religion has enforced the taboo nature of sexuality, urging its participants to abide by sexual mores under fear of social exclusion and judgement. These rigid heteronormative sexual health rules enforce the taboo nature of sex while masquerading as morality (Murry, 1997; Timmerman, 2001). Public awareness of the work of prominent sexologists such as Kinsey and Masters and Johnson has no doubt helped to moderate the impact of religion on sexuality. Still, as Foucault (1978) and others (e.g., Parker, 2009) have argued, discourses arising from religion still guide many people's attitudes and behaviours in this important area of human experience.

The media and popular culture are additional means through which sexual norms and mores are perpetuated. Citing the results of social and media researchers, Sanchez and colleagues (2012) postulated the media inundation pairing "men with dominance and women with passivity" as one explanation for the acceptance of traditional gender scripts.

Ward (2016) synthesized empirical investigations into the effects of media on sexuality, systematically reviewing research from 1995–2015. This research stemmed from a number of fields, including social and developmental psychology, women's studies, and communications. Ward provided a metalevel overview of the field and focused on the sexual objectification of women and girls in the media. Consistent exposure to these types of images and messages increases body dissatisfaction, self-objectification, sexist and adversarial sexual beliefs, and tolerance of violence towards women. Additionally, this type of content diminishes views of the competence, morality, and humanity of women (Ward, 2016). Eaton and Matamala's (2014) quantitative study examined the relationship between heteronormative beliefs and sexual coercion and found that internalized endorsements of heteronormative beliefs (as portrayed in media and popular culture) may encourage sexual coercion in relationships.

As demonstrated, perspectives on sexuality and human sexual behavior are influenced by a variety of social forces. Pornography, although doubtless an additional influence on sexuality, remains controversial. Research on the influence of pornography has focused on sexual risk and permissiveness as well as sexual behaviors, violence, and the acceptance of sexual violence. Gorman (2014) found that viewing pornography is correlated with the sexual acts found arousing and performed by individuals consuming it; it also shapes the behaviors and attitudes of those who view it. This is especially concerning given the numbers documented by Lim, Carrotte, and Hellard (2016), who reported that "between 37% and 88% of mainstream pornographic scenes include acts of physical aggression (mostly gagging and spanking), most commonly towards female actors" (p. 3). While difficult to define, the margins of pornography have become wide

enough to include the pornographisation of culture (for instance, soft-core pornographic images represented in fashion magazines). The politics of pornography have shifted some over time. Initially feminist activists called for the censorship of porn but these voices have gradually paled with the recognition that porn is a fixture of culture (Boyle, 2006; Williams, 2004).

Pornography is pervasive, mass produced, and consumed worldwide. In their recent review of research on the effects of viewing pornography, Lim et al. (2016) were able to draw few definitive conclusions from the empirical evidence. There is growing evidence that young people are using pornography to inform their sexual experiences. The impact of this is yet unknown. While empirical evidence establishes consistent links between violence against women and viewing pornography, these links are either correlational or in lab-based settings with questionable applicability to real-life situations. The impact of viewing pornography on sexual well-being generally indicates adverse impacts but is similarly limited. Furthermore, pro-pornography evidence includes research that documents positive outcomes including, for example, that couples may experience mutually beneficial sexual experiences from watching pornography together (Lim et al., 2016; Weitzer, 2011), improvement in sex life, improvement in attending to the sexual needs of a partner, and feelings of comfort and open-mindedness regarding sex (Lim et al., 2016). Certainly, there is debate around the positive and negative influence of pornography and Lim et al. (2016) make it clear that despite any positive outcome or influence, it seems there is ample evidence to the contrary and more research is required to produce insight into pornography and its impact.

Heteronormativity influences and is influenced by various social factors including

pornography, the media, and religious values and mores. Practicing within this largely heteronormative social context, social workers have an opportunity to challenge or affirm these assumptions within their work. Knight et al. (2013) examined the experiences of male clinicians and clients in sexually transmitted infection testing in clinics and found the clinicians had employed some strategies to alleviate client anxiety and counteract the production of heteronormativity and its harmful effects (for instance, by providing gender-neutral services). However, Knight et al. (2013) likened this to a neutralizing or censoring of gender and sexual identity, which may in fact reaffirm heteronormativity. Certainly this study reinforces that, not only is heteronormativity difficult to combat, it is also harmful to clients and clinicians alike in its inherent privilege of "normal" (Knight et al., 2013).

Section conclusion. This section of the literature review has provided some historical and current understandings related to central concepts in the relatively young field of sexuality. As discussed, sexuality has come to be acknowledged as a vital part of being alive that is best conceptualized as a multifactorial phenomenon influenced by biology, psychology, culture, and time. It is this multi-dimensional conceptualization of sexuality that serves as the foundation for this research project. It is important to place the current conceptualization of sexuality in context because this research project explores how social workers construct their own knowledge around sexuality given the aforementioned multifactorial phenomenon. Social workers have professional lenses and reflective skills through which to understand and examine social dynamics and dominant discourses. At the same time, and perhaps depending on the extent of education in sexuality they received in their degree programs, social workers may be influenced by

messages about and perspectives on sexuality that constrain their capacity to engage in anti-oppressive practice in this area of practice.

Given its central importance to individual and social dimensions of living, sexuality could perhaps be assumed to be within the scope of social work practice generally. As discussed in the next section, sexuality can be affected by many problems or circumstances that bring people (or couples or families) to social workers.

The Importance of Sexuality in Social Work Practice

As discussed earlier, sexuality has become recognized as a vital and central component of human experience. Dunk-West and Hafford-Letchfield (2011) have argued that within social work it is important that sexuality be understood to comprise not only "our individual psyches and bodies," but also "societal attitudes and values" (p. 15). Based on these perspectives, social workers may encounter sexuality and/or sexual health at any level of practice—counselling, policy, advocacy, community work, or education. At the macro level, a social worker could be, for example, pushing for policy change and reproductive health for vulnerable populations. Micro level examples include social work roles supporting couples and individuals with sexual health related issues in counselling or psychotherapy, or working in a sexual health or abortion clinic to provide resources, education, and emotional support.

Social workers may encounter sexuality and related topics at any level of practice across diverse fields of practice or professional contexts. In the following section, I discuss the social work mandate and examine the literature with respect to social work practice with members of the LGBT community. I then highlight the need for sexuality knowledge and skills in social work by discussing common fields of professional

practice. While literature in these areas of traditional concern in social work may be helpful in establishing some understanding of the importance of sexuality, overemphasis on problem areas could potentially lead to neglecting the larger implications of sexuality across areas of specialization and failing to look at sexuality from a structural perspective. By largely focusing on individualized definitions and impacts, sexuality appears to enter social work awareness only within specific fields of practice, rather than as a dominant socio-cultural influence important for macro level work. My thesis research, in line with the postmodern conceptions of sexuality discussed above, considers implications of social constructions of human sexuality on social work practice. Thus, the final sub-section addresses the importance of sexuality for social work at this broad, structural level.

Social work mandate. Pelts, Rolbiecki, and Albright (2014) described social work as "the largest human services provider with marginalized populations" (p. 136). The tenets of social work should impact a social worker's desire and ability to address sexual health goals within practice with clients. Motivation to address these needs may be inspired by the social justice goals and ethical practice requirements within social work, and should inspire clinicians to consider and work with the sexual needs of clients. Social justice seeks to amend social and economic conditions such that equal distribution can occur and is particularly integral to the ideologies and aims of social work. Both social justice and ethical practice focus on eliminating inequalities, and what makes this so important to work in sexuality is the attention paid to eliminating the inequalities based on gender or sexual orientation and the discrimination thereof.

The Canadian Association of Social Workers (CASW) *Code of Ethics* (2005),

which was approved by the Alberta College of Social Workers (ACSW) in 2007, remains conspicuously quiet about the topic of sexuality, reflecting the gap in literature, scholarship, and interest in the topic within the profession. The *Code of Ethics* does recognize personal and professional identity including sexual orientation and gender and their potential influences on practice, and lays out a clear expectation that social workers are not to discriminate based on these characteristics (CASW, 2005).

The Standards of Practice (2013) for Alberta social workers is also fairly quiet on the topic of sexuality. The document does define a dual relationship (wherein multiple roles exist between worker and client) as potentially having sexual implications and prohibits social workers from engaging in sexual relationships with their clients (ACSW, 2013). While this is important to protect vulnerable clients from a potentially harmful experience, one is reminded of Jeyasingham's (2008) concept of negative sexuality in which social work explores sexuality only within situations of negativity, around what should not be done rather than imploring social workers to engage in ethical practice by working to understand the sexuality of clients.

It is important to note as well that the national educational accrediting body (Canadian Association for Social Work Education, CASWE) mentions sexuality only once in their Standards for Accreditation (2014). They affirm that sexual identity is part of diversity and as such guides the principles of accreditation in social work education programs. However, similarly to the CASW *Code of Ethics (2005),* the education standards do not lay out specific expectations around knowledge and skill requirements for students around sexuality more broadly defined beyond orientation (Canadian Association for Social Work Education, 2014).

Social work and LGBTQ clients. Social workers may routinely work without knowledge of, or even need to know, the client's sexual orientation. At other times, issues related to sexual orientation or the lesbian, gay, bi-sexual, transgendered, queer and questioning (LGBTQ) community may be a key reason for the professional interaction. In these situations, specific topics could include, for example, "coming out, discrimination, and lack of support from their families and religious communities" (Eubanks-Carter, Burckell, & Goldfried, 2005, p. 2). There is some empirical evidence that social workers could be asked to support clients with respect to these kinds of concerns with relative frequency. A 2003 survey reported by Eubanks-Carter et al. (2005) found 42% of therapists regularly "dealt with LGB issues in therapy" (p. 1). In the introduction to their recent study, Pelts, Rolbiecki, and Albright (2014) reviewed evidence of a "high incidence of mental health disorders among lesbians and gay men" and that "lesbian, gay, and bisexual youths were five times more likely to attempt suicide than their heterosexual peers" (p. 132).

Research evidence supports the assertion that social workers will likely need to address issues related to sexual orientation in practice. Unfortunately, there is also evidence that social workers are often unprepared to positively address issues experienced by members of the LGBTQ community. For example, the results of an extensive qualitative study (over 500 participants) of the experiences of LGBTQ youth in the child welfare system described "negative stereotypes and beliefs about LGBTQ people" as the "number one barrier" to positive child welfare services (Woronroff, Estrada, & Sommer, 2006, p. 2). While not denying that many workers demonstrated knowledge and compassion, the report noted that "discriminatory and abusive" practices

were not uncommon (p. 4). The report encouraged an increase in educational opportunities for workers to eliminate ignorance and discrimination, as well as comprehensive policies to meet the needs of youth (Woronroff et al., 2006).

There is some evidence of social work interest in sexual orientation and gender identity. Social work researchers have examined social work student attitudes towards LGBTQ clients and heterosexism, the commitment among social work programs to include curriculum inclusive of LGBTQ content, and the inclusion of LGBTQ content in social work journals. With respect to social work student attitudes, quantitative surveys by Logie, Bridge, and Bridge (2007) and Raiz and Saltzburg (2007) found somewhat similar results. According to Logie et al. (2007), there is evidence of relatively accepting attitudes among (Canadian) Master of Social Work (MSW) students toward topics related to sexual orientation. The students in this study were more likely to demonstrate higher phobia regarding gender-identity and bisexuality. Raiz and Saltzburg (2007) found that approximately 20% of (U.S.) students expressed "intolerant" attitudes toward sexual minorities while 80% were either "tolerant" or "tolerant with conditions" (p. 60). Logie et al. (2007) considered preparation for practice in this area, finding that students generally expressed a lack of readiness. The question of preparation for practice was more recently considered by Laverman and Skiba (2012). Among the 170 participants in their survey, "less than half felt prepared to handle most areas of human sexuality in future work." Brownlee et al. (2005) also examined social work students' attitudes and advocated increased education about LGBTQ issues; these authors also reported the encouraging finding that as students progressed from year one through year four, homophobic attitudes decreased.

Research on the contribution of social work education to the preparation of students for competent practice in this area is in line with these findings. The results of a 2009 survey of directors of post-secondary social work programs (undergraduate and graduate) indicated that most programs are not assessing their students' competence in addressing LGBTQ issues and that program capacity to adequately prepare students to approach these issues is likely lacking (Martin et al., 2009). Fredriksen-Goldsen et al. (2011) studied perceptions of and attitudes toward LGBTQ content generally from a faculty perspective, while McInroy, Craig, and Austin (2014) asked LGBTQ-identified students about the adequacy of curriculum addressing gender identity compared with sexual identity. Both studies used self-report survey methods with random selection (and moderate response rates), with the McInroy et al. (2014) study also including a written qualitative component. The findings from both faculty and students converged on key findings: first, that faculty were moderately prepared and resourced to include curriculum on sexual identity but less so with respect to gender identity. Among faculty, Fredriksen-Goldsen et al. (2011) also found that with respect to both sexual and gender identity issues, curriculum focused on "population differences" as opposed to "structural inequalities" (p. 29)—that is, less focus on experiences of, for example, homophobia or transphobia. Both Fredriksen-Goldsen et al. and McInroy et al. concluded that students are likely relatively ill-prepared to adequately address issues related to practice with the LGBTQ community, particularly with respect to issues related to transgender.

Finally, two studies have examined how well LGBTQ issues are represented in key social work journals. In 2002, Van Voorhis and Wagner found content on homosexuality "barely visible" (p. 352) in the social work literature between 1988 and

1997. Within the social work journals considered by Van Voorhis and Wagner, only 3.92% of the articles focused on homosexuality and, among these, most pertained to HIV/AIDS. Pelts, Rolbiecki, and Albright replicated the Van Voohris and Wagner process just over a decade later (2014). They found that between 1998 and 2012, the sexual orientation focus in social work journals actually decreased from the first review, with articles on homosexuality accounting for only 2.40% of the literature in social work journals. In the second review, the authors noted a decrease in the number of articles focusing on HIV/AIDS. In other ways, however, sexuality content had stayed consistent across the decades: over half of the articles focused on clients, approximately 35% on practitioners, and less than 10% on macro level issues. These authors encouraged social work education to take a holistic perspective, including sexual orientation issues in curriculum in order to produce practitioners who exhibit attitudes of inclusion around sexual diversity.

Taken together, the findings of social work research on LGBTQ issues is alarming. Not only has this issue been relatively invisible (Van Voorhis & Wagner, 2002), the little empirical evidence that does exist suggests there are still issues with ignorance and homophobia in today's social work classrooms. Lacking or receiving only limited sexuality-related content during their education, social workers may be ill-prepared to support LGBTQ clients. These workers are at risk of imposing unexamined heteronormative assumptions or theories in their practice that do not fit this population and perpetuate compulsive heterosexuality (Fish, 2008; Knight et al., 2013). Furthermore, it is possible that the content available regarding LGBTQ community and issues focuses on micro-level concerns. According to Fish (2008), "there is an

assumption that LGB people do not experience oppression" (p. 183), which likely impacts social workers' abilities to work effectively with these clients and to advocate for change at the broader level. A holistic focus of social work education to include sexual orientation issues in curriculum may produce practitioners who exhibit attitudes of inclusion around sexual diversity and who are able to practice on micro as well as macro level intervention.

Sexuality implications within fields of social work practice. The importance of knowledge and skill in the area of sexuality is not limited to social workers' interactions with people who are from the LGBTQ community. Issues related to sexuality are likely to be implicated across a diverse range or practice areas of interest to social work. As noted by Tepper (2000), "sexuality as a source of pleasure and as an expression of love is not readily recognized for populations that have been traditionally marginalized in society" (p. 285). Social workers are among the helping professionals that have struggled to view certain groups as sexual beings, including people coping with illness, recovering from sexual violence, living with disabilities, or moving into older age (Tomlinson, 1999). Graham and Padilla (2014) argued that "marginalization is a key contributing factor and a result of the absence or violation of sexual rights and gender equality" (p. 251). People from these groups are often "othered" and excluded from dialogue about human sexuality. In the following paragraphs, I discuss some of the literature related to how topics related to sexuality may arise in some common areas of social work practice. This review is not exhaustive nor is it intended to cover all of the fields of practice in which social workers would encounter sexuality as an important topic. The purpose of this section is to demonstrate how sexuality can arise in numerous social work

conversations and settings. Understanding how sexuality can be affected in such diverse ways will inform my understanding of the research interviews with social workers from a variety of backgrounds.

Sexuality and health. Social work has a strong presence in health care, with the majority of health care social workers practicing in hospital settings (Whitaker, Weuismiller, & Clark, 2006). If health care is expanded to include mental health, the involvement of social workers is exponentially greater, with 37% of social workers identifying that they work in the specialty area of mental health (Whitaker et al., 2006). Addressing sexuality-related concerns is no doubt an important aspect of a medical social worker's role. There is considerable research evidence regarding how the physiological and psychological effects of illness can directly and indirectly impact sexual functioning (George et al., 2014; Steinke, 2013; Verschuren et al., 2010).

Despite the likelihood of encountering issues related to sexuality in practice in health care settings, there is evidence that health care professionals have difficulty discussing sexuality. Studies within cancer and palliative wards by Hordern and Street (2007) and Quinn, Happell, and Browne (2011) found that conversations with patients around sexuality were largely medicalized or problem-focused. These authors acknowledged that discussing issues of sexuality with cancer patients may feel awkward or may seem unimportant given the other health issues of the patients, but they also underscored the value of reflective practice in increasing comfort with sexuality-related conversations. Reflective practitioners understand the complexities and the importance of sexuality and addressing it within the clinical setting, they value rapport building with patients and understand the impact of their own personal experiences and definitions of

sexuality and intimacy, and they work to create open and honest spaces where patients can feel comfortable discussing sexual health. Hordern and Street (2007) urged clinicians to utilize a reflective style of communication in order to understand how sexuality impacts their clients. Quinn et al. (2011) encouraged clinicians to reflect not only on their attitudes but also on their practice experiences. While these studies are qualitative in nature and not intended to be generalized, they nonetheless offer valuable guidance for working with sexuality in health care settings.

Speaking specifically to mental health workers in health settings, Buehler's 2014 book, *What Every Mental Health Professional Needs to Know about Sex*, acknowledged the sexual health and functioning challenges of clients who struggle with health issues or cancer. She maintained that patients struggling with cancer can have satisfying sex lives with the proper support. Sexual side effects may be experienced due to medication, or may be experienced due to the impact of the diagnosis of mental health issues such as an increase in anxiety or depression. Clinicians can have a positive impact on patients' challenges, but Buehler warns against simple interventions like providing a pamphlet, an action that suggests the clinician is uncomfortable with the topic (Buehler, 2014).

Much of the literature related to sexuality and chronic illness has been written by health care professionals more traditionally aligned with medical care than social workers (e.g., nurses, rehabilitation specialists). In one of what appears to be few social work-specific articles, Cagle and Bolte (2009) discussed the importance of the profession particularly in sensitive health care areas such as palliative care. These authors noted the reticence of most social workers to broach the topic of sexuality with patients. Like other authors (Enzlin, 2014; Steinke, 2013), Cagle and Bolte (2009) stressed particular skills

for social work in this area such as the ability to take a reasonably thorough sexual history as part of assessment, and to provide psychoeducation related to the medical condition impacting the patient's sexuality. The goal of social work intervention or therapy in these situations is to help the person meet their optimal level of sexual functioning and develop a positive sexual identity as they live with the health/mental health condition. In summary, this literature supports the need for social work practitioners in health care to be knowledgeable and skilled in the area of sexuality, and suggests there is the need for enhanced education in this area.

Sexual violence. According to research evidence, between 18 and 25% of women and up to 10% of men experience rape or attempted rape in their lifetimes (Gavey & Senn, 2014). Women from typically oppressed racial, ethnic, occupational, and ability backgrounds are reportedly at increased risk than women from more privileged backgrounds (Gavey & Senn, 2014). Common psychological consequences for victims include post-traumatic stress disorder (PTSD), depression, anxiety, and a range of other diagnoses (Beckerman, 2002). The prevalence of sexual assault, especially among vulnerable and marginalized women, and the range of negative outcomes for survivors renders it likely that survivors will come to the attention of social workers if not because of the experience directly, then for one of the myriad of problems often associated with sexual victimization. Since social workers hold an integral role in the provision of services for both the victims and perpetrators of sexual assault and may encounter survivors in various practice contexts, they should be aware of the potential impact of sexual assault on sexual functioning and have the ability to support the person's recovery in this area.

Child sexual abuse is another form of sexual violence that may be part of the background of many clients who come to the attention of social workers. Systematic reviews of the data regarding the prevalence of child sexual abuse worldwide indicate that between 9 and 17% of girls and between 3 and 8% of boys are victims of child sexual abuse, specifically forced intercourse (Barth, Bermetz, Heim, Trelle, & Tonia, 2013; Putnam, 2003). While sexual abuse may be experienced across all socioeconomic and cultural groups (Finkelhor, 1993), a number of factors place some children at greater risk than others for sexual abuse. These risk factors include age, gender, disability, socioeconomic status, race and ethnicity, and family composition. As with adult sexual assault, these risk factors are especially pertinent for social work practitioners who are typically engaged with such marginalized groups (Prior, Lynch, & Glaser, 1999). Furthermore, child sexual abuse has been linked with a variety of psychological consequences such as PTSD, depression, and substance abuse (Horner, 2010), which can be typical "presenting problems" among clinical social work clients.

The impact of child sexual abuse can be devastating to the victims over the long term and across multiple domains of living (DiLillo, 2001). Consequences often include the survivor's sexual health and functioning in later life because of both psychological and physiological implications. Compared with non-abused women, women with histories of child sexual abuse report higher levels of conflict with intimate partners, less satisfaction in intimate relationships, lower levels of sexual satisfaction, and greater sexual distress (Cummings, Berkowitz, & Scribano, 2012; DiLillo, 2002; Meston & Lorenz, 2013). Male survivors of child sexual abuse experience psychological and social impacts such as depression, suicidality, distrust of others, and feelings of shame,

helplessness or rage (Fisher, Goodwin & Patton, 2008; McDonald & Tijerino, 2000). As when working with survivors of adult sexual assault, it is imperative that social workers be attuned to the potential for sexuality-related problems among survivors of child sexual abuse. Discomfort or lack of skill regarding sexuality risks re-victimizing clients or silencing their experiences.

Foster care. In the context of foster care and adoption, approaching topics of sexuality with clients should be a requirement as sexuality informs clients' sense of self and relationships, as well as how they interpret society. Children and adolescents need support to understand sexuality as part of healthy development. This may be complicated by a history of trauma or sexual abuse that may, in turn, lead to more negative consequences such as sexual risk taking behaviors or distorted views of sexuality. Positive messages about sexuality are noticeably absent from literature about work with children and youth who have experienced trauma or other mental health issues (Fava & Bay-Cheng, 2012). Encouraging a trauma-informed practice model with youth, Fava and Bay-Cheng (2012) argued that this approach can be helpful in honoring resilience while promoting sexual health and positivity towards sexuality.

In social work assessment in the field of foster care/adoption, workers are responsible for conducting comprehensive and competent assessments inclusive of sexuality. Collecting life history from clients is likely to shed light on sexual relationships or trauma and sexual thoughts, feelings, and actions. Social workers must be aware that interviewing clients is a co-construction process rather than fact-finding, and they should have the knowledge and skills to interpret sexual history taking in this way (Hicks, 2008).

Sexuality and people with disabilities. Social workers with strong self awareness and deep grounding in skills and knowledge about sexuality may be particularly needed in work with people who are differently abled. Structural stereotyping is especially enforced with people with physical or developmental differences, marginalizing them in multiple ways, including that society largely sees them as asexual (Mona, Syme, & Cameron, 2014; Tomlinson, 1999). People within the intellectually/developmentally disabled community are typically viewed as incapable of making their own sexual health choices, including those of gender or orientation.

Research on counsellors' attitudes towards disabled individuals and sexuality has indicated that most clinicians do not consider sexuality relevant to the discourse on the disabled (Gray, House, & Eicken, 1996; Willert & Semans, 2000). The sexual health needs of differently abled populations are largely omitted from the education of professionals in healthcare. According to Kattari (2014), there have been few studies "on how people with physical disabilities experience sexuality" (p. 499). In sexual health education for those with special needs, messages of positive sexuality are not presented and sexuality is typically referred to using a heteronormative lens (for fear of being too confusing), or framed in a victim/violence or medical context (Winges-Yanez, 2014). Winges-Yanez (2014) argued that this is counter to the social work code of ethics, neglecting the principles of respect for inherent dignity and worth of persons, social justice, and recognition of the importance of human relationships. He called for social workers working within this field to address their ethical obligation to advocate for more inclusive sexuality education for those with disabilities (Winges-Yanez, 2014).

Sexuality and people who are elderly. Although elderly people can continue to have active and engaged sex lives, society, and even health care professionals, may view this group as devoid of sexual behaviors or desire, and may tend to minimize, ignore, or avoid the topic of seniors' sexuality (Bradway & Beard, 2015; Tomlinson, 1999). For the growing number of social workers practicing with people in old age, training in this area may lack any depth if it exists at all as scholarship fails to address sexuality in later life, especially with same-sex couples (Bradway & Beard, 2015). Viagra is a top-earner for the powerful pharmaceutical industry, which, along with the aggressive marketing of this drug to the elderly, belies the myth that seniors are not sexually active (Frances, 2013). Given the universality of aging, social workers need to become knowledgeable about and skilled in addressing the needs of this population.

Willert and Semans (2000) claimed that keys to sexuality work with people who are elderly are education and normalization, and using these tools would be helpful, not only for the older people themselves, but for clinicians as well. A recent study by Flaget-Greener, Gonzalez, and Sprankle (2015) found evidence of the importance of education in this area. Among 119 psychologists, there was a statistically significant relationship between attitudes toward sexuality among older persons and education/training in sexuality. Although working with a sample of U.S. psychologists, the finding likely has relevance for social workers as well. Walker and Ephross (1999) found that seniors living in long-term care expect the care staff to be knowledgeable about and comfortable with addressing sexuality. These authors contended that clinicians must "ensure that the best possible care is given to their clients. Further, in failing to question elderly clients about their sexuality or by assuming them asexual, clinicians not only do them a

disservice, but also risk doing harm" (p. 431). As our population ages, clinicians have a responsibility to address the sexual health concerns of the elderly in a knowledgeable and comfortable way.

Discourse/macro level. Regardless of the focus of their particular practice, all social workers are ethically obligated to attend to macro level issues. Sewpaul (2013) argued that social workers can confront internalized domination or the normalization of privilege by critically examining the institutional reproduction of sexism. In the area of sexuality, this includes addressing societal oppression of sexual minorities that impact large scale issues such as discrimination in employment (Gates, 2011/12) and rates of homelessness (Pelts, Rolbiecki, & Albright, 2014). According to Pelts et al. (2014), there is a "significant lack of literature related to issues that impact people who identify as lesbian and gay on the macro level" (p. 135). Further, they described the risk of ignoring the macro level and overemphasizing the individual level as continuing the victim blaming of LGBTQ people. A recently reported research study involving over 3,800 LGBQ participants in the United States found that, compared with individuals who identify as cisgender, those who identify as transgender experience more frequent employment and housing discrimination (Kattari, Whitfield, Walls, Langenderfer-Magruder, & Ramos, 2016). Based on their results, the authors argued that, along with other helping professionals, social workers need to be able to identify and work against transphobia at the macro policy levels.

Sanchez, Fetterolf, and Rudman (2012) provided a review of evidence documenting the consequences of adhering to traditional gender roles that ascribe men with powerful, dominant positions and women with weak and submissive positions.

They acknowledged that generalizing the research findings in this area should be done tentatively as most studies have involved self reports from university students. According to their review, experiences of both men and women are negatively impacted by external pressures to conform to gender norms. Research evidence has suggested that these effects are experienced not only within sexual/intimate relationships but also extend to work and other social contexts. With respect to sexual relationships, consequences for women and men conforming to gender role expectations include differences in control, sexual self-efficacy, and sexual assertiveness between genders, with women experiencing greater sexual problems and lower sexual satisfaction. Outside of sexual relationships, Sanchez and colleagues (2012) noted that conforming to traditional gender scripts differentially effects men's and women's likelihood to express "dominance, assertiveness, aggression, and self-promotion," which are more associated with agentic masculinity, while "obedience, compliance, and nurturance" (p. 171) are associated with feminine passivity. The authors reviewed evidence that the traditionally accepted male sex script contributes to "a culture of violence" (p. 173), potentially increasing the likelihood of aggressive behavior toward female partners. They also describe "backlash"—"penalties for counterstereotypical behavior" (p. 174). These include major implications in the workplace, where passive men and aggressive women (gender deviant individuals) seem to be dismissed, disliked, or viewed as less hirable or undermine by others. These findings are presented despite assumptions that men and women's roles are moving toward egalitarian ideals and the authors concluded that continuing to ascribe to traditional sexual scripts creates problems in engaging in "authentic, rewarding sexual expression" (p. 168).

A review of research by Eaton and Matamala (2014) documented evidence linking adherence to traditional sex roles (heteronormativity) with verbal and physical sexual coercion by men against women. These researchers developed a measure of the heteronormativity construct and studied the relationships among endorsement of heteronormativity and acceptance, experience, and perpetration of sexual coercion using a large sample of university students (N=555). They found that heteronormativity (endorsed equally by males and females) was correlated with endorsement of sexual coercion, with both males and females reporting the perpetration of sexual coercion. As with other research in this area, conclusions regarding causality (i.e., that acceptance of heteronormativity *causes* sexual coercion) are constrained by the correlational design of the research and the generalizability of the findings is limited given the convenience sample of university students.

Baker, Brown, and Ragonese (2015) explored the impact of sexualization on teenage girls and associated this type of discrimination with mental health issues such as disordered eating and depression. They warned that sexualization pervades media, television, and advertising, signaling to girls how they *should* behave and diminishing their agency. Social workers can make a positive impact on systems through anti-oppressive practice, and on girls through provision of healthier empowering opportunities (Baker et al., 2015).

Jackson and Scott (2010) situated the importance of sexuality on the macro level for the construction of gender and marginalization as follows:

> Sexuality has occupied a pivotal and also problematic place in the construction of the binary divide of gender and of all the other dichotomies associated with it. At

> first sight it would seem that sexuality "obviously" belongs on the side of nature, the body and unreason—the feminine side (hence the idea of women as saturated with sex, governed by their sexual organs). Yet there is also a tradition, dating from the nineteenth century, of active sexuality as masculine and as rationally ordered—a drive that women lacked. (p. 57)

While social work can be neglectful of macro level issues as they relate to sexuality, social workers have an obligation to attend to the discourse level of social issues and oppression.

Section conclusion. Social workers have a responsibility to work with marginalized clients and to strive towards the goals of social justice. In this section of the literature review, I have outlined how sexuality can enter into some common fields of social work practice. My intention has not been to suggest that sexuality-related concerns are limited to these areas within social work practice but, rather, to stress the ubiquity of sexuality regardless of problem or focus area. Rather than contributing to the discourses, policies, and practices that silence concerns related to sexuality, the profession of social work can contribute to enhanced social justice by increasing knowledge, skills, and research in these fields so that practitioners can competently address sexual health needs regardless of field of practice. The following section seeks to expand upon and explain the theories which inform sexuality in the helping professions.

Sexuality in the Helping Professions: Theory and Practice

Sexuality-related helping has not only created its own "profession" but is also considered a field of practice within several disciplines, with considerable variation in terms of interventive approach depending on the favored understanding of sexuality and

sexual health. Among the main disciplines in which "sexuality" and/or "human sexual behavior" would be considered an area of clinical interest are: medicine (general and psychiatric), nursing, psychology, and social work. A cursory appraisal of the literature across these areas indicates that there has been an increase of sexuality research, literature, and journals in recent years (Bucholtz & Hall, 2004; Parker, 2009; Verschuren, Enzlin, Dijkstra, Geertzen, & Dekker, 2010; Woody, 2011). However, this trend seems not to pertain specifically to social work, as articles related to sexuality have decreased in social work journals and seems to indicate a disinterest in this field (Pelts, Rolbiecki, & Albright, 2014). Since social work's influence is not strong in this area, drawing on insights emerging from other, allied disciplines is important.

Research regarding attitudes toward and comfort with sexuality among helping professions seems to have been more frequently done by social work allies in mental health, rehabilitation, and nursing, than by social work scholars. While generalizing these findings should be done cautiously, commonalities across the professions argue their relevance for social work. Research from allied professionals has generally indicated that incorporating sexuality into practice is predicted by sexuality-specific knowledge and comfort levels (Juergens, Smedema, & Berven, 2009; Quinn, Happell, & Welch, 2013). Major barriers to these discussions included: lack of training or embarrassment (Haboubi & Lincoln, 2003); lack of confidence; the perception that patients do not think nurses will address sexuality with them (Magnan & Norris, 2008; Magnan & Reynolds, 2006); sensitivity and complexity of the topic; demographic characteristics such as gender, age, and sexual orientation (Gott, Galena, Hinchliff, & Elford, 2004); and feeling as though it is "not their job" (Quinn et al., 2013). The barrier

included most often across the literature is the constraint of time (Gott et al., 2004; Haboubi & Lincoln, 2003; Magnan & Norris, 2008; Magnan & Reynolds, 2006). Another barrier was that patients do not expect sexuality-related conversations with practitioners (Magnan & Norris, 2008; Magnan & Reynolds, 2006). A major theme across the discussions in these studies relates to the need for education around sexual health issues to increase comfort and to enable practitioners to perceive fewer barriers to discussions of sexuality.

A field that has perhaps not felt these same challenges, and particularly not around discomfort, is sex therapy. What follows is a brief overview of the field/discipline of sex therapy and a discussion of how sexuality-related helping is discussed in social work and other helping professions. This is important to my research because borrowed knowledge from other disciplines may be helpful for the social work approach to sexuality and is applicable to this research project in the sense that it provides some direction for clinical work with clients in this field.

Theory and practice of sex therapy. McCarthy (2015) claimed that sex therapy was introduced in 1970, and Buehler (2014) argued that Masters and Johnson invented sex therapy. While Masters and Johnson's approach to sex therapy was more psychoeducational than psychotherapeutic, what grew out of multiple frameworks is postmodern sex therapy: "In its postmodern guise, sex therapy was supposed to target all problems that could possibly impact on sexual function and employ a variety of theoretical perspectives to do so" (Binik & Meana, 2009, p. 1020).

Some authors promote sex therapy or sex counselling as a distinct specialization or discipline while others critique this approach. On the "pro" side of the argument are

Southern and Cade (2011) who claimed that most mental health professionals are not equipped to deal with sexual health issues due to their lack of training. They advocated a model of evidence based, biopsychosocial approaches that take into account "postmodern corrections to the medicalization of sex therapy" (p. 251). On the other side of the argument are authors like Buehler (2014) and Binik and Meana (2009) who have maintained that, by specializing the field of sexuality, societal discomfort is perpetuated. Moreover, specializing the field of sex therapy may serve to undermine the profession, making integrated, holistic treatment less likely (Berry, 2013b; Binik & Meana, 2009; Buehler, 2014). Further undermining the professionalization of sex therapy is that it is unregulated. Lacking agreed upon standards, people with little sexual health expertise can work with clients. Sex therapy associations, such as the American Association of Sexuality Educators, Counselors and Therapists (AASECT) and non-certifying associations such as the Society for Sex Therapy and Research (SSTAR), though well intentioned, lack rigourous vetting and may dilute the field (Binik & Meana, 2009; Buehler, 2014). Sex therapy is a broad field that changes with social developments and in which practitioners may use a variety of theoretical frameworks. As sexuality can impact any aspect of human life including self-esteem, mood, and relationships, Buehler (2014) has encouraged each sex therapist to "be a good diagnostician, excel at quickly developing rapport, and have adequate training in treating couples as well as individuals" (p. 263).

Sexuality in clinical social work practice. As stated above, social workers can indeed practice in the field of sex therapy, but not all sex therapists may be social workers, and may gain credentials in other fields that enable them to practice sex therapy.

Writing from a social work perspective on sexuality and sex addiction, Woody (2011) gave an explanation of social work relative to sexual counseling. According to Woody (2011), the responsibility should be left with practitioners:

> to determine their interest in and competence for providing various levels of service. Clinical social workers without expertise in sexuality and sexual disorders who wish to offer assessment and treatment must commit to an independent or formal program of study to gain competence for ethical practice in this area. For many reasons . . . (e.g., the complexity of the problem, the tentativeness of treatment ideas, and the potential for transference and countertransference), working with the issue of hypersexuality is not for the faint of heart. (Woody, 2011, p. 317)

During the sexual revolution of the 1960s, social work scholars and educators began to incorporate sexuality. By the 1970s, the lack of attention to sexuality in social work education was being highlighted and practitioners were encouraged to consider sexuality as an important component of competent practice. During the 1980s, it appears there was increased interest and attention paid to human sexuality within social work, specifically around homosexuality (Laverman & Skiba, 2012). Beginning in 1982, a periodical entitled *Journal of Social Work and Human Sexuality* was published. The journal covered topics related to human sexuality generally—for example, sexuality as expressed within various cultures, feminist approaches to sexuality—as well as topics concerning problem areas within the field—for example, child sexual abuse, homophobia, and sexual addiction. This journal stopped publishing in 1994 and, however valuable the articles once were, the age of the articles now draws into question

their current relevance. McCave et al. (2014) asserted that the discontinuation of this journal has left a gap in social work scholarship.

As described above, two reviews of social work literature that encompass 1988–2012 document the dearth in social work literature related to sexuality. Van Voorhis and Wagner's (2002) initial review (1988–1997) indicated that social work literature neglected aspects of human sexuality and suggested increasing the focus on strengths as well as social justice. In their recent follow-up, Pelts, Rolbiecki, and Albright (2014) found similar results. They claimed that some studies continue to expose heterosexist attitudes in social work and, as mentioned earlier, that the proportion of articles written with a sexuality focus in key social work journals decreased since Van Voorhis and Wagner's review from 3.92% to 2.40%.

As the fate of the *Journal of Social Work and Human Sexuality* and the reviews in 2002 and 2014 demonstrate, social work interest in knowledge or skill development in areas related to human sexuality has not been sustained. The profession is committed to issues of social justice, service to humanity, and caring for the most vulnerable populations (CASW, 2005). In previous sections, I discussed the likelihood of social workers encountering clients from the LGBTQ community, and experiencing sexuality-related issues across a range of fields of practice. As also discussed earlier, social workers should be at the forefront of work at the level of challenging heteronormative discourses. The profession has been encouraged to consider how it contributes to these discourses—for Hicks (2008) this area is fundamentally important as he implored: "most importantly, we need to ask how social work is implicated in the specification of sexual subjects, or of sexuality, in the first place" (p. 66).

Recent contributors to the field of sexuality in social work include Hicks (2008), Jeyasingham (2008), Rowntree (2014), McCave et al. (2014), and Dunk-West, Hafford-Letchfield and Quinney (2009). These authors have generally critiqued the state of sexuality scholarship in social work and have offered recommendations for practice and research in the area. However, no specific model for social work practice in sexuality has developed. As described above, research has demonstrated that social work education largely ignores or sustains dominant heteronormative discourses about sexuality. Sehl (1998) implores that therapists' sexual feelings toward their clients have to be addressed with frankness in the classroom. If not, it is as if school becomes a replica of a family situation, where sex is assumed to be "bad" because it is never mentioned. (p. 52)

Given the inadequacy of social work education regarding sexuality, it is likely that, when working with sexuality, practitioners choose between existing perspectives largely derived from other (albeit allied) professions. In the next section, I review some of these major approaches.

Approaches to helping in sexuality. Given the historical context through which our understanding of sexuality developed over time, how previous sexologists and sex therapists framed helping is crucial. This may be especially important in the study of sexuality, given the lack of education about sexuality coupled with influence of popular culture on sexuality. The following section outlines approaches to helping organized into three groups: pathology-oriented, competency-based, and postmodern-informed. Within each group, specific sub-types are briefly described, and pros and cons relative to social work are identified. It is important to include these models given that social workers may approach their work from these frameworks and conceptualize their helping practices in

these ways, potentially working within challenging structures. These models may begin to lend themselves to an understanding of sexuality for social workers.

Pathology-oriented models. The roots of pathology- or disease-oriented models to helping in sexual health can be traced to the "early" and "middle" years of the field of sexuality (Atwood & Klucinec, 2007), discussed previously. The following section outlines three models that continue to be dominant within the profession of social work, at least in part due to the influence of medicine throughout the ages: psychoanalytic theory, the medical model, as well as the related psychiatric model.

Psychoanalytic theory. Key tenets of Freudian theory were included in the previous discussion of the history of sexuality. Freud's influence on psychoanalysis was enduring; before the 1960s psychoanalysts believed humans were dominated and motivated by their libido and aggressive drives, with emphasis on id, ego, and superego (Coady & Lehman, 2008).

Feminists or queer theorists often take issue with psychoanalysis for what they argue is its gendered or libido focus. Psychoanalysts approach sexuality around desire and perversion, which some argue are influenced by traumatic developmental processes (Downing, 2015). McCave, Sheperd, and Winter (2014) have suggested that psychoanalysts find it difficult to engage with clients about sexual health issues, especially in regards to atypical sexuality. Psychoanalysis can be a vulnerable experience for the client and clinician; sexual boundary violations may be problematic for some practitioners (Martin, Godfrey, Meekums, & Mahil, 2011). The relationship between analyst and patient is key in the process and conceptualized through the lenses of transference and countertransference. The term "erotic countertransference" is derived

from psychoanalysis, and perhaps indicates continuing Freudian influence on psychoanalysis (Rodgers, 2011). Boundary violation, countertransference, and emotional engagement in psychoanalysis appears to be viewed in different terms by different authors. Some feel as though an intense relationship between client and analyst is helpful (Mitchell, 1988; Ogden, 2004), whereas others view the analyst's emotional involvement as detrimental (Friedman, 2010). Rodger's (2011) research into therapist understanding of erotic transference found that all therapists had sexual feelings towards clients. The issue may not be whether or not helpers react sexually to their clients, but rather, how they cope with those reactions.

Over the course of its long history, psychoanalysis has had its fair share of champions and critics. Scholars and psychoanalysts agree that the profession is focused on sexuality (Berry, 2014; Celenza, 2010; Southern & Cade, 2011) and explanations for issues based on childhood experiences and relationships as well as unconscious mental process. Not all scholars agree with its effectiveness (Southern & Cade, 2011). However, psychoanalysis and its use of the talking cure can help some clients move through trauma, make cognitive shifts, alleviate distress, and increase self-reflection (Brand Bartlett, 2002).

Exploring psychoanalytic theory relative to social work, Bower (2004) posited that psychoanalytic theory can address the gaps within social work by providing a model of human development and relationships, and specifically, understanding how external adversity impacts internal processes. Moreover, she claimed that psychoanalytic theory is congruent with the realities of the world in which social work is practiced (Bower, 2004). However, psychoanalytic theory has its limitations and in academic settings in

Canada, this practice is not widely emphasized, perhaps reflecting the view that the psychoanalytic approach is "outdated, pathologizing, unscientific, sexist, culturally irrelevant, lacking in evidence-based support, and ill-suited to the reality of social work practice" (Rasmussen & Salhani, 2010, p. 210).

Medical model. The medical model gained traction in the 1970s. Previously, a more psychological focus on sexual problems and their treatment dominated social work, largely based on the research and the work of Masters and Johnson. Advances in medical technology and the introduction of medications such as Viagra fueled the dramatic shift to the medical perspective (Asher, 2007; Berry, 2014; Bradway & Beard, 2015; McCarthy & Thestrup, 2008; Tiefer, 2006). While Viagra may have had a positive impact on sexuality in later life, the medicalization of sexuality also has its downfalls. As Bradway and Beard (2015) explained: "[Viagra] arguably led to the overdiagnosis of sexual dysfunction, as such a medicalized and deficit-based model enabled men to seek a quick fix for their problems while ignoring any potential social or psychological causes and unintended consequences" (p. 506).

The medical model has been criticized for treating the patient without considering his or her unique context, rather than the more holistic focus of other perspectives. For example, feminists have largely rejected the medical model, which they view as a perpetuation of the masculine, patriarchal model of sexuality, and instead have encouraged focus on relational and cultural factors (Bradway & Beard, 2015; Southern & Cade, 2011). Social work as well has vocalized concerns about the dominant medical model, arguing that it is both pathologizing and stigmatizing (Casstevens, 2010).

According to some critics, the medical model reflects the power of the dominant

group and its control of marginalized and oppressed groups (Bell, 2014; Nyanzi, 2006). Practice based on this model may neglect and ignore social and interpersonal dynamics that are important to sexuality (Hart & Wellings, 2002). For example, regarding the lived experiences of women seeking assistance in reproduction, Bell (2014) argued that the medical model devalues the perspectives of the women, resulting in epistemic injustice. She claimed that the medical model is inflexible when it comes to addressing reproductive health: the doctor is put in a position of knowing and the patient is marginalized and disempowered. The patients' experiences of marginalization are perpetuated by what Bell called "testimonial smothering" (wherein the marginalized group edits the expressions of their experiences in the hopes of being heard by the dominant group) and "testimonial quieting" (wherein the dominant group actively ignores or fails to validate the marginalized group) (Bell, 2014). Nyanzi (2006) also critiqued the positivist, biomedical approach to sexuality, asserting that it oversimplifies complex, nuanced, and ambiguous concepts. She suggested an alternative to this approach, urging us to "explore the wider meanings embedded within sexuality to generate more context-specific conceptualisations that violate rigid blueprint definitions" (p. 1852).

The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) (*DSM–5*) (American Psychiatric Association, 2013), discussed in the following section, has had an important role in the medical model, as well as in the pathologizing of sexuality. As an example, previous versions of the *DSM-5* (with the '5' designating the edition number) formerly categorized homosexuality as a mental disorder, a diagnosis that was removed in 1973. Proponents of the *DSM-5* value categorization and classification which they argue can lead to standard practice and effective treatment (Buckley, 2014). The *DSM*

also helped to move sexual behaviours that were once considered deviant and sinful into a perspective that included the medicalization rather than "perversion" of sexual health issues (Downing, 2015; Parker, 2009).

Psychiatric model. Throughout its history, the *DSM* has shifted and changed alongside beliefs about sexuality, reflecting social and cultural progress while trying to reflect developments in the empirical evidence base. It manages to remain responsive to the changes in scientific and public opinion while being shaped by practicality, social change, and politics (Boskey, 2013). The most recent iteration of the *DSM (5)* includes some significant changes regarding issues of sexuality. For instance, sexual dysfunction is now a stand-alone criterion and diagnosis separate from paraphilias and gender dysphoria (formerly gender identity disorder). While previously the *DSM* was quite disparaging of sexual variance, the *DSM-5* now appears to have de-stigmatized and normalized a broader range of sexual experiences and expression (Boskey, 2013; Woody, 2011).

Social work has traditionally advocated for people on the margins, and in so doing, rallied against the medical model and pathologizing what social workers understand to be consequences of social structures. However, social workers are often the quietest voice in the room. For example, social work had no editorial role in the creation of the *DSM-5* (Lyter & Lyter, 2016; Washburn, 2013). Nevertheless, at least based on evidence from the United States, social workers provide the majority of mental health services (Cohen, 2003; Mechanic, 2008) and mental health is the largest specialization among social work practitioners with 37% identifying their specialization as mental health (Whitaker et al., 2006). Over the evolution of the *DSM* since 1952,

social work has offered a variety of criticisms, and situated from a social work perspective, Woody (2011) commented: "the evolution in the *DSM* shows that normative (conventional) sexual activities, under certain conditions, could merit the diagnosis of a mental disorder" (p. 304).

Controversy regarding the *DSM-5* has been apparent even in popular media and has prompted psychological groups and associations in the United States to circulate petitions regarding potentially problematic new diagnostic criteria (Littrell & Lacasse, 2012). Perhaps not the least significant of these problematic diagnoses is the continuing inclusion, albeit sometimes with softened language, of sexual, gender, and paraphilic "disorders." The *DSM-5* has discursive power to sort people into "normal" and "abnormal" by naming, classifying, and controlling (Downing, 2015). The change in paraphilia from older versions to the new *DSM-5* is mostly in the shift of wording from "diagnosed" to "ascertained," which may initially appear less oppressive. However, the *DSM-5* maintains focus on sexual distress or impairment. What continues to be left unclarified is the source or cause of the distress. The problem is assumed to be from within the individual instead of resulting from social structures, especially including the dominant discourse of heteronormativity. Like its earlier editions, the *DSM-5* focuses on distinguishing "normal" sexual behavior—precopulatory and copulatory activities—suggesting that sexual activities outside of this narrow "normal" scope are problematic, unhealthy, and reflect individual pathology. Individuals with sexual identities, tendencies, and practices that do not fit inside the fairly narrow norm are "ascertained" to have a mental disorder (Downing, 2015). Being diagnosed as having a mental disorder may have its own ramifications of shame from stigma and discrimination (Rüsch, Todd,

Bodenhausen, Olschewski, & Corrigan, 2010). This shame, in turn, may impact the client's ability and willingness to seek professional help or support from social networks (Rüsch et al. 2010).

Based on these critiques, it can be argued that the *DSM-5* contributes to perpetuating heteronormative assumptions (Downing, 2015). At the same time, it is important to recognize that some people benefit from the process of diagnoses and consequent mental health treatment. By classifying mental health conditions, agencies are able to provide services for distinguishable concerns, and health professionals are able to communicate amongst themselves as well as with their patients and the systems in which they work. Additionally, there can be commonalities across countries and cultures in respect to training professionals to provide services (International Advisory Group, 2011). Social work's role in this may be in the initial support and referral, screening and evaluation, diagnosis, provision of psychotherapy, case management, or advocacy (Whitaker et al., 2006).

Competency-based approaches. The following section outlines and provides some critique of competency-based approaches for sexual health, including the biopsychosocial model, anti-oppressive practice, and trauma-informed practice. Each approach has some place in the provision of services related to sexuality. These models have received criticism, especially recently. For example, Edwards (2016) critiqued the notion of "cultural competence." She discussed what she calls a "culturally intelligent" approach for clinical social workers. "Cultural competence," through which social workers are perceived to be able to work within all cultures, may be unreasonably ambitious even though it remains a widely used concept in the profession. Edwards

posited that social work education and practice has been responsive to diversity but needs to react with cultural intelligence to revere the intersectionality of clients lives within multicultural, multiethnic identities (Edwards, 2016). This may be a model that could be expanded to include sexualities.

The biopsychosocial model. Sexual health writers and researchers who advocate for a biopsychosocial model of sexual health argue that this perspective can account for diversity in both sexual experience and characteristics, as well as an understanding of the complex dimensions that inform our understanding of sexuality (Berry & Berry, 2013; Russell, 2012). According to Willert and Semans (2000), "psychosocial factors play a salient role in elderly sexual problems" (p. 422). This model views sexuality as important and honors the interconnected and holistic understanding of sexual health. According to Nappi (2015) biopsychosocial factors may include: "medical conditions, psychiatric comorbidities, chronic diseases or side effects from substances/medications/surgical procedures, partner's general and sexual health/relationship difficulties, prior experiences, personal norms, etc." (p. 877).

Clinicians working from a biopsychosocial approach may utilize a number of treatment methods to support a client's sexual health (Berry & Berry, 2013). This approach was integral to the work of Masters and Johnson who emphasized a pleasure approach to sexuality through a biopsychosocial view of sexual problems (Almas & Almas, 2016). Tolman and Diamond (2014) underscored the importance of approaching sexual health with a structural lens: "experiences of sexual desire are inextricably linked to the historically and culturally specific belief systems in which people are embedded, and therefore rendering suspect the notion of a culture- or context-free, biologically

determined experience of sexual desire" (p. 16).

One variant of the biopsychosocial model is the developmental and life stage perspective. Social work practice that combines the biopsychosocial and developmental approaches may be effective to support clients as they explore and understand the various factors that may impact sexuality, and how these vary by life stage. Social work has incorporated the biopsychosocial and developmental models in other fields of practice (Zittel, Lawrence, & Wodarski, 2002), which suggests it might also be a fit regarding sexuality-related concerns. Like the biopsychosocial model, the developmental approach does not reduce sexuality to one single factor, but rather understands the impact of biological, psychological, social, and cultural factors (Carpenter & Delamater, 2012). Further, the life course perspective recognizes sexuality as fluid and ageless, expressed on a personal level within individuals but also within larger contexts of sociopolitical systems. A significant strength of this perspective on sexual health is the ability to reflect upon the relationships between sexual experiences in early and later life by appropriating sexuality as a lifelong process (Hansel, 2014). Despite its strengths, a drawback of this approach to sexuality is its newness. For example, there has yet to be articulated a model acknowledging the range of sexuality-oriented experiences throughout the lifespan. Authors in this area have only recently started to move away from adult sexuality as being the only normative stage for sexual experiences.

Anti-oppressive practice. For many social workers, anti-oppressive practice is the model that most clearly pursues the social justice goals of the profession. A key aspect of anti-oppressive practice is examining the ways structural disadvantages negatively impact people's lives (Cocker & Hafford-Letchfield, 2014). Lena Dominelli, an acknowledged

leader in this area, conceptualizes anti-oppressive practice as a holistic approach that recognizes the impact of culture, key social institutions, political systems, and relationships in the perpetuation of social inequality (Dominelli, 2002). Anti-oppressive practice has hardly concerned itself with sexuality, but sexually atypical individuals (LGBTQ populations) have certainly experienced oppression through, for example, the denial of same-sex marriage rights, "don't ask don't tell" policies and the inclusion of homosexuality in the *DSM*. Within social work specifically, the field has perpetuated heterosexism and failed to take up anti-oppressive practice in such subtle ways as assuming the client is heterosexual or cisgendered on various assessment forms and paperwork (Fish, 2008). However, Baker, Brown, and Ragonese (2015) encouraged social workers to address issues of sexuality and sexualization within their practice given the profession's unique anti-oppressive and strengths focus, which makes them uniquely positioned to lead this charge.

Trauma-informed practice. A trauma-informed approach to practice acknowledges that clients may have suffered trauma, and pursues treatment and intervention sensitive to that possibility. By utilizing a trauma-informed approach, clinicians can endeavor to minimize the risk of revictimization, triggering, or retraumatization. Adapting language and using a non-judgmental attitude that includes respecting boundaries as well as demonstrating knowledge and awareness can be cornerstones of this approach (Auteri, 2015).

Sexual health professionals have only recently taken an interest in trauma, but there seems to be a continuing gap in this literature. Cohn (2016) reinforced the impact of psychosocial factors on sexual health issues, asserting that by disrupting the balance of

the individual or couple through the trauma experienced, sexual problems may develop. By gaining knowledge of the interplay between sexual function and trauma, clinical work can be improved. These concepts can be incorporated into healing for the individual or couple, effectively establishing a trauma-informed approach for human sexuality. Cohn (2016) also drew similarities between sexuality and trauma by claiming both are taboo—or at least uncomfortable—topics of conversation.

While the trauma-informed approach respects the lived experiences of vulnerable and traumatized clients, it is not without drawbacks. Trauma-informed practice is not a theoretical orientation and cannot stand alone but instead needs to be incorporated within broader theoretical frameworks. A trauma-informed approach may be helpful in creating understanding of the client's history but may not adequately recognize the structural influences that inhibit or enhance the issues of the client.

Postmodern approaches. The term "postmodernism" incorporates both a critique of the "conventional positivist world view . . . as increasingly irrelevant" and "advocates a new paradigm based on the valuing of difference, multiple realities and the 'death of the meta-narrative'" (Ife, 1999, p. 214). While many authors are suspicious of the relativism inherent in postmodernism (Fawcett & Featherston, 2005), its proponents argue that it offers a dynamic, collaborative enhancement to anti-oppressive models, keeping the goal of social justice intact (Cocker & Hafford-Letchfied, 2014). According to Rossiter (2005), postmodernism represents a dual crisis for social work (p. 24). The crisis of knowledge challenges social workers with the argument that reality is socially constructed through language rather than existing as objective and unchanging. That is, what was once accepted as reality can be understood as meta-narratives that can be

challenged. Understanding that reality is produced from the "social location and context" of the knower (Rossiter, 2005, p. 28) allows us to hear perspectives that have previously been unstoried. With its concern for social justice, social work should attend to how multiple, intersecting discourses construct and maintain privilege and, by definition, marginalization (Rossiter, 2005). According to Rossiter (2005), the second crisis posed by postmodernism for social workers is one of identity. Using a Foucaldian analysis, Rossiter (2005) argued that social workers are implicated as part of the modern knowledge/power regime that regulates "normality" that by definition includes some and excludes others. This is a fundamental challenge to social work's "innocent" self-conception as a beneficent profession (Rossiter, 2005, p. 31), and one, according to Rossiter, the profession has only begun to recognize. The way forward for social workers, from the feminist postmodern perspective articulated by Rossiter (2005), is through vigilant attention to power and our complicity with it, and a key way to achieve these is the use of critical reflexivity.

Within the sexuality field, there are some social workers (Dunk-West, 2014; Hicks, 2014; Jeyasingham, 2014a) practicing and writing from a postmodern perspective. Exploring the implications of postmodernism for feminism and for topics of concern in social work such as sexuality may be helpful in situating the need for and approach to this research project. The three practice approaches to sexuality I describe below draw on critically informed approaches, feminism, and queer theory.

Critically informed postmodernism. There are a group of social work authors who approach sexuality from a critically-informed postmodern perspective. For example, Hicks (2008) recognized that social work maintains heteronormative discourses, failing to

challenge dominant assumptions about gender and sexuality. He also problematized the concept of gender, noting that filtering humanity through "male" and "female" labels reinforces heteronormativity. Hicks outlined recommendations from writers in the field; however, his suggestions appear to be narrowly focused on practice with individuals—for example, encouraging social workers to increase their understanding of homosexual clients and their specific needs. Hicks's comments in this regard may function to support heteronormativity by tacitly endorsing heterosexuality as the norm and suggesting that all homosexuals share similar experiences and problems. He has suggested that, by examining how social workers approach and think through sexuality, we can start to undo the processes that keep heteronormativity intact. While Hicks's (2008) work made a valuable contribution, his presentation of what he terms "sexuality" is dated in that he limits the concepts within his writing to sexual orientation.

Jeyasingham (2008), who, like Hicks, is a social work academic in the United Kingdom, has argued that social work often concerns itself with sexuality. His contention is based on drawing distinctions between positive and negative interpretations and expression of sexuality, and the claim that social work fails to concern itself with "positive" sexuality such as eroticism but does involve itself with "negative" sexuality. For instance, rather than exploring erotics or pleasure, it concerns itself with sexuality's social defined sexual pathologies or problems. This happens because of the stigmatizing and marginalizing context in which social work is practiced, dealing in dangerous and challenging situations such as sexual abuse, infertility, or exploitation is much more common than dealing with positives such as pleasure. By dealing only with the dangers rather than including the positives, social work can inadvertently contribute to

perpetuating heternormativity. Baker et al. (2015) also argued that social work fails to normalize sexuality and instead frames it within the context of risk. In order to make changes, Jeyasingham (2008) encouraged social work to engage with "positive" sexuality, and work to weave these issues of heteronormativity and privilege into social work education around sexuality.

Rowntree (2014) recently argued that many social work scholars continue to understand sexuality through a heteronormative lens. When it is directly addressed, discussions of sexuality encompass not much more than orientation or identity, and fail to reflect upon practices or desires. Rowntree (2014) argued that sexuality is not fixed, but rather constitutes a social axis intersecting with other potentially malleable social axes including class, race, age, gender, and ability. Rowntree's (2014) arguments inform my research in terms of the need to attend to and better understand intersectionality and its relationship to social work practice.

Rowntree (2014) described efforts to influence sexual health education for social work students in Australia, but noted several challenges. She wove sexuality into a course within a wider curriculum, rather than creating a stand-alone sexuality course. Additionally, the course with the sexuality content was an elective rather than a requirement, so that not all social work students in the program would graduate with this sexuality component. Students in these courses are encouraged to reflect upon the historical and cultural implications of sexuality (the pathologizing of homosexuality), as well as social work's historic complicity with heteronormativity. It appears Rowntree's focus in her sexual health education remains on sexual orientation, perhaps excluding broader aspects of sexuality important to social work practice. What I found most

interesting in Rowntree's curriculum is the exercise completed by the students addressing their own attitudes and understanding of sexuality. Students are also asked to explore what factors influence these attitudes (Rowntree, 2014). Through this exercise, students attempt to identify the discourses that inform what they otherwise might take for granted as "natural." This is of particular interest to me as identifying discursive influences among social workers' beliefs about and practices related to sexuality is one goal of my thesis research.

Feminist theory. The complexity of women's experience around sexuality, socialization, gender roles, and sexual function can perhaps best be addressed with the use of postmodern feminist theory. This framework is committed to social liberation, targeting institutions of oppression that are rooted in power relationships between genders (Bywater & Jones, 2007; Tolman & Diamond, 2014). Concerned with patriarchy perpetuated by social, economic, and political structures, postmodern feminist theory is a natural fit for social work and sexuality. In addition to helping to understand gender and how gender is created and maintained throughout society, it sheds light on sexuality for women and how society dictates how we interpret experiences as females. Judith Butler, feminist, queer theorist, and poststructuralist philosopher, has offered valuable contributions to this way of knowing and she has argued that much violence is created worldwide by masculinist ontologies and epistemologies that disadvantage women (Green & Featherstone, 2014).

Social work clinicians drawing from the postmodern feminist perspective recognize and address the power dynamics and sex roles in relationships and may, at times, work to develop sexual assertiveness and liberation for women (Tiefer, 2010).

Feminist theoretical approaches seek to disrupt the androcentricity of societal expectations. Feminist theory encourages social workers to maintain attention on the macro level regarding women's concerns as societal issues, and working to address systemic oppression and inequality. Postmodern feminist theory is a good fit for social work and issues of sexuality given its focus on both gender and social change and its emphasis on learning about the real lived experiences and oppression of women. Judith Butler, who, like Foucault, views power as decentered and fluid, presented the example of how babies are gendered at birth, effectively subjectifying the pre-existing state of power (Cocker & Hafford-Letchfield, 2014). Extrapolating from understanding gender as socially constructed, she argued that the biological construction of sex is, in itself, gendered and socially constructed as well; that we as humans do not possess a gender but rather perform a gender to varying abilities and levels of comfort. While committed to gender as a focus of analysis, feminist theorists also attend to the interactive effect of various social locations that influence women including race, class, culture, and ability.

Queer theory. Queer theory, which has been described as a subordinated voice and perspective in social work (Turney, 2014), was named to reclaim the use of a word that has signified oppression and marginalization. Theorists working from this perspective strive to deconstruct the division between hetero- and homosexuality, gender, and identity. Queer theorists acknowledge the fluidity of gender and the understanding of "othered" individuals within society (Bywater & Jones, 2007) while rejecting and opposing binary thinking and the oppression felt from the heteronormativity of the global culture (Cocker & Hafford-Letchfield, 2014). Butler and other queer theorists share ideas with psychoanalysis to support the assertion that sexual identities and orientations are

subordinated and therefore never stable, a claim made by Freud (Penney, 2013). Heckert (as cited in Nash, 2010) emphasized the fluidity and intersectionality of queer and explained:

> I can no longer see any clear border between anarchist and queer. Perhaps this is because I understand both terms as referring not only to refusal to grant legitimacy to borders, whether those of classes, nations or sexualities, but also as ways of becoming, of learning to experience the unreality of borders, to know profoundly that they have no independent existence. (p. 42)

Hicks (2008) and Jeyasingham (2008) have agreed that social work scholarship has not utilized concepts of queer theory to inform practice around sexuality. As already discussed, literature regarding sexuality in social work has focused predominantly on sexual orientation and identity. Queer theory explores desire, social interaction, and behavior and targets heteronormativity and homophobic aesthetics, effectively addressing these gaps in social work education (Jeyasingham, 2008). Queer theory is important to social work practice as it is a meaningful way to address sexuality and look structurally at sexual oppression and othering.

Section conclusion. In this section of the literature review, I have provided an overview of approaches to helping related to sexuality. Pathology-oriented models focus on deviance, while competency-based models tend to assume social workers can "know" diverse experiences and help from within that knowing. Postmodern approaches enable a framework from which to understand and organize experiences while rejecting the assumption that only rigourous, scientific methods create valid knowledge. Instead they acknowledge diverse forms of knowledge creation and knowing, emphasizing cultural

and structural context. These approaches are useful to deal with sexuality and social work from a perspective of helpful and realistic critique.

Conclusion—Constraints/Inducements

The literature related to sexuality and social work practice indicates that clinicians believe sexuality is important, but do not often talk about it with clients. Attitudes about sexuality are important to their work and there are a number of factors that facilitate or act as barriers to comfort and attitude in discussions of sexuality. Furthermore, researchers and clinicians have agreed that more research and scholarship on the topic is imperative in order to better equip counselors to serve clients. It is also important to mention the lack of variation of methodology within the research, which has been dominated by the use of surveys (Asher, 2007; Eubanks-Carter et al., 2005; Fredriksen-Golden et al., 2011; Logie et al., 2007; Raiz &Saltzburg, 2007; Sehl, 1998). The quantitative, survey approach generates results that are useful in terms of generalizability and replicability. However, they do not provide the richness and nuanced data achieved through the qualitative approach. Given the complicated and sensitive nature of the topic of human sexuality, qualitative research can add to our understanding of sexuality within the helping professions that is currently largely reliant on studies using the survey approach.

Little is known about the extent to which different characteristics and experiences influence clinician comfort level in discussing sexuality. A variety of studies, including explorations of barriers to addressing sexuality, the attitudes of social work students, and counselor education have all attempted to encourage discourse and further understanding

in this field, but no studies have considered the specific research questions asked in this thesis project.

As indicated through this literature review, sexual issues are common for individuals and couples, and research has indicated that people who experience sex issues are likely to experience mental health issues such as anxiety and depression (Davison & Huntington, 2010; Pelts, Rolbeicki, & Albright, 2014). Issues with mental health, sexual dysfunction, or marital stress may prompt individuals and couples to seek out the expertise of a social worker, psychologist, or nurse and requires clinicians to be engaged in and prepared for these often challenging conversations.

Failing to address the sexual health needs of our clients can be detrimental to mental and physical health, the development of relationships, sexuality, and self-esteem as well as undermining the therapeutic relationship or negatively impacting treatment goals and outcomes (Russell, 2012). Sexuality influences and impacts most areas of a human life, but also across human life to structural constructions of gender and socialization. Through this research I hope to increase understanding about the attitudes of social workers towards working in human sexuality in order to address the barriers and facilitators to these conversations. The major aim is to improve client care by improving social work attitudes through education. As we have seen, this is an area of interest for researchers who advocate increased discussion related to sexuality in education as well as in clinical settings. The researchers seem to agree that more focus on sexuality and more research in this arena would be of benefit to the field of social work in the future.

What does the review of the literature mean for this research project? Social workers are influenced by the contexts in which they live and work and, therefore, can be

expected to reflect both the advances related to sexuality and the continuing challenges, perhaps including unquestioned heteronormative assumptions and values. Based on the extant literature, most social workers likely have little sexuality-specific social work education. Still, they are mandated to be reflective, self-questioning professionals; most social workers have no doubt questioned their own attitudes and beliefs about sexuality. The existing literature indicates that social workers will identify a variety of constraints and inducements for their own approach to sexuality in practice. The empirical evidence suggests that social workers who have some education specific to sexuality hold more favorable attitudes towards discussing sex with their clients. Social workers' attitudes may vary with their own gender and the genders of their clients, or their age and the age of their clients. Social workers' knowledge and attitudes may be impacted by social forces such as religion, media messages, and pornography. My impression, perhaps more informed from my own experience as a social worker providing counseling to mental health patients than the empirical evidence, is that the theoretical orientation and practice model of the worker will influence the likelihood of the clinician to engage in discussions of sexuality with their clients. In the discussion chapter, I reflect at length upon my own position as a social worker relative to this research.

Chapter Three: Methods

To address the research questions that can summarized overall as, "What are social workers' attitudes and experiences engaging their clients in discussions of sexuality in a therapeutic context," I used a qualitative feminist lens. In keeping with this methodology, I designed and facilitated semi-structured individual interviews with 14 participants and used Thematic Analysis (Boyatzis, 1998; Braun & Clark, 2012; Guest, MacQueen & Namey, 2012) to structure the data analysis process and protect rigor. In this chapter I first discuss the qualitative, feminist methodology. Given its centrality to feminist research, I include a section on reflexivity, or "positioning the personal" (Deshong, 2013). I then describe the study methods, including participant recruitment, procedure and data collection, and the data analysis process. Finally, I discuss the concept of rigor in qualitative research and describe the steps I took to protect rigor in this study.

Methodology

In the following sub-sections, I describe the "methodologies," or framework of assumptions, informing the study at the broad level: qualitative and feminist research. I then describe the study's specific "methods," or the specific tools and techniques used to complete the research process.

Qualitative research. Qualitative research is based on what many characterize as the interpretive paradigm. The interpretive paradigm stands in contrast to a positivist approach; research based on positivist assumptions strives to map an objective reality, and research based on interpretivist assumptions considers subjectivity a given. The interpretive paradigm is unconcerned with understanding phenomena through

measurement and is instead interested in the meaning (both personal and social) within social discourses and expressed by participants (Guest, MacQueen & Namey, 2012). Boyatzis (1998) explained that, while positivist and interpretive social sciences are likely to be regarded as radically different concepts, using an interpretive approach allows social observations to emerge in a way that may satisfy the discovery process of the positivist social scientist, wherein the construction of meaning may emerge as social "facts." Qualitative approaches based on interpretivist assumptions utilize methods such as observation and interviewing, and often result in data analysis from thematic approaches (Brisolara, Seigart & Sengupta, 2014).

The qualitative, feminist approach I used for this thesis research facilitated a flexible, exploratory stance. Drawing meaning from the data can be accomplished in a variety of ways, which is part of what attracted me to aligning myself with qualitative research. Qualitative approaches are increasingly regarded as legitimate research, as evidenced by their acceptance in growing numbers of professional journals and conferences (Probst, 2015). Specifically, in this research, I used a "generic" approach, which refers to a qualitative method that is "not underpinned by a specified theoretical perspective" (Smith & Bekker, 2011, p. 40). Cooper and Endacott (2007) explained that the generic qualitative approach is used to understand and describe a phenomenon when the investigator is not situating the study within a particular philosophical orientation (such as hermeneutics or phenomenology). Further, they suggested that research studies seeking to explore participants' perspectives should be distinguished from those aiming to develop a theory, as with the grounded theory tradition, for example (Cooper & Endacott, 2007).

Feminist research. Methodologically, the topic of sexuality is a fit for feminist research given the relationship between sexuality, gender and power (Atwood & Klucinec, 2007; Parker, 2009; Eichler, 1991; Fletcher, Dowsett, Duncan, Slavin & Corboz, 2013) and its methods are appropriate for empirically investigating my specific research question. Research informed by feminism encourages recognition and understanding of the lived experience of the participants within broader societal expectations and influences resulting from patriarchy. In keeping with anti-oppressive ideals in social work (Crocker & Hafford- Letchfield, 2014), a feminist conceptual framework encourages and enhances non-hierarchical relationships within the data collection process (Brisolara, Seigart & Sengupta, 2014). In the following paragraphs, I summarize key points regarding feminist-informed research.

As Gringeri and colleagues (2010) and Deshong (2013) have pointed out, there is no one definition of feminist research. Rather, feminist research is generally concerned with upsetting the androcentric bias, and can utilize a number of different methods although it tends to be more frequently qualitative than quantitative. The tenets, values, principles and ideas of feminist inquiry can be utilized effectively with any number of research methods (Gringeri, Wahab & Anderson-Nathe, 2010). Some authors have pointed out the distinctions between modern and postmodern feminism and the influence of that distinction on research. Trinder (2000) described the postmodern approach as founded on a relativist ontology, presuming local specific constructed realities and analyzing gendered discourses and their intersectionality. Modern feminism relies on a post-positivist ontology, which leads to fixed notions of gender, beliefs about violence against women, and how to make structural change (Fletcher, Dowsett, Duncan, Slavin &

Corboz, 2013). Modernist feminism has significantly advanced various causes understood as "women's issues." However, postmodern feminism may offer avenues for social work research and practice to move to a more inclusive social justice orientation. Turney (2014) explained that, for a time, social work was not able to make pursuing a "just society" its goal because of the influence placed upon "difference" by postmodern literature that neglected the centrality of social class. With respect to sexuality, postmodern feminism supports the recognition of diverse voices within the context of unequal gender relations in much the same way that the emphasis on multiculturalism by social services has grown from the oppression and marginalization of groups of service users (Turney, 2014).

While feminist research is conceptualized in a variety of ways, some central qualities tend to be featured consistently. Feminist research typically strives to validate and give voice to the lived experiences of women and other oppressed groups (Tomm, 1989). Hall and Stevens (1991) contended that, not only should feminist research validate women's lived experiences, it should recognize the structurally oppressive conditions of their lives and be geared toward accomplishing social change. A feminist orientation guides researchers to understand and explore problems and challenges that have largely been ignored, including issues of sexuality (Eichler, 1991). Feminist research often uses qualitative methods, which allow participants to become more meaningfully involved than do more traditional research approaches. For example, the interview is not seen as leading to objective "truth;" rather, it is seen as a joint accomplishment between researcher and participant through which the interviewee's experiences and self-identity can be examined (Trinder, 2000). Additionally, in feminist-

informed research, consciousness-raising is utilized as a methodological tool, and ethical research practice is underscored (DeShong, 2013).

A principal distinguishing feature of feminist research is attention to the researcher's subjectivity. Feminist research requires the researcher to practice reflexivity, that is, intentionally examining her own experiences and assumptions, and how her life and lens has been shaped by society. Daley (2010) argued that the researcher's use of reflexivity can be a response to and recognition of social power within the research generally and the interview specifically. Furthermore, practicing reflexivity provides opportunities for the researcher to consider not only her choices throughout the research, but also her own social identity (Daley, 2010). There is space within reflexivity to consider how the physical body of the researcher may impact the dynamics of the research and process (Daley, 2010). For Probst (2015), reflexivity is a way to continually acknowledge that the researcher shapes and interprets the encounters and the data, and thus must exercise caution to use this power appropriately. Reflexivity is a process of situating oneself and offers the opportunity to reduce bias in the research. Claiming reflexivity is "a cornerstone of good quality feminist research" (p. 402), Gringeri and colleagues (2010) offered specific direction for feminists performing social work research. The researcher is encouraged to examine her own personal characteristics such as race and gender and how they might intersect to compound the experience of discrimination (Carr, 2014). Gringeri et al. (2010) suggested that the researcher ask what she brings to the project through previous experiences, interests and identity. Gringeri et al. (2010) explained that reflexivity requires that the researcher consider how she can manage the influence of these aspects of herself on the project. Cooper and Endacott

(2007) characterized reflexivity as a quality issue, important for attaining rigour. Probst (2015) also deemed reflexivity essential for rigour and characterized it as an "an eye that sees itself while simultaneously seeing the world" (p. 38).

Offering additional insight into reflexivity is DeShong (2013) who characterized reflexivity as "positioning the personal" and argued its importance as "a reminder that all knowledge is indeed political and embedded within particular relations of power" (p. 8). She encouraged researchers to go through a process of examining and identifying how their personal values, social location and choices impact the knowledge produced in the research. My own process of "positioning the personal" is included in the next sub-section of this Methods chapter.

A feminist approach is in line with my research in several ways. First, my study intends to give voice to lived and often subjective experiences of social workers through non-hierarchical interviews. Second, this research is intended broadly to examine the social constructs that impact these experiences with an emphasis on gender, sexuality, androcentricity and heteronormativity. Finally, it is my hope that the results of my study will contribute to literature, informing practice and education, and supporting inclusion of sexuality toward the eventual, ultimate goals of creating discourses of equality and inclusion within social work.

Positioning the Personal

Reflexivity and the collaborative creation of knowledge between investigator and participant are hallmarks of research from within the interpretivist paradigm. According to DeShong (2013), "it is essential to consider our own biographies and biases even as we seek to make claims about the lives of those we study" (p. 10). As discussed above,

reflexivity is particularly a key component of feminist research. I explored my biases, assumptions and questions with my classmates and supervisor and kept a journal throughout the process of conducting my study. It is my hope that in so doing I have been able to utilize myself, my experiences, and my practice to the best advantage of the research. Because I work in a field so similar to that of most of the research participants, I believe I am able to bring a sophisticated level of awareness and understanding of their experiences and worldviews. According to Probst (2015), "consumers of social work research, as well as those whom their work ultimately serves, should be able to trust the authenticity of the knowledge offered to them. The practice of reflexivity can support this aim" (p. 47).

To situate myself within the research, an important part of both feminist and qualitative approaches, it is necessary to introduce my personal and professional background. I will use Deshong's (2013) suggestions about positioning the personal: locating personal values, social location and choices within the research.

Social location and personal values. First and foremost, I am a social worker. I grew up in Edmonton, in a white, middle class family that went to an Anglican Church every Sunday. Academics and the arts were emphasized in my upbringing by my parents, both of whom are medical doctors. My two older brothers are both academics and professionals; the eldest holds a PhD in psychology and specializes in sex therapy; and the younger is a medical doctor who currently works for a large drug company. Aside from the compulsory birds-and-the-bees talk, which I received from my mother when I was six years old with the help of an educational video tape, sexuality was seldom

discussed in my home. While premarital sex was discouraged, never was I inhibited from dating.

I grew up blocks from the University of Calgary Faculty of Social Work, Edmonton division. I have a distinct childhood memory of asking my mother, "What is social work?" and her explaining to me that it involved helping those who were less fortunate or marginalized. I knew at the time and have known ever since that social work is my purpose and passion; I strive to embody my personal values of social justice and compassion within my research. I also appreciate that being white, able-bodied, cis-gendered, and middle class gives me considerable privilege. I need to be careful that the power that comes with this privilege does not overly influence the research process. For example, my privilege may mean that my research participants, already potentially feeling less powerful because of the status given "research" and "researchers" in Western societies, may feel vulnerable with me or unable to voice their opinions or perspectives freely. Through my personal and research journals, I have constantly reminded myself of my social location and the impact on the research process, especially around my interactions with the participants. In this way, I have attempted to remain mindful of the need to work to establish a sense of equality between us, by expressing my gratitude to the participants, and approaching each interview with a respectful curiosity.

Research choices. I completed my Bachelor of Social Work degree (BSW) at the same school about which I had asked my mother years earlier. No courses covered content related to sexuality; however, I did seek out a human sexuality course offered online as an elective and completed this valuable option in basic sexual health for the generalist social worker. I made note of the gap in sexuality-specific content and when I

returned to the Master of Social Work (MSW) program in the same faculty, I became the relentless student, reiterating in the classroom, the importance of issues of sexuality. Throughout my internships and in various workplaces I have practiced since graduating, sexual health has been neglected and ignored by practitioners. I have always wondered why this seems to be the case, as I understand that sexuality is an integral part of human existence. Neglecting sexuality in social work seems incongruent with our profession's emphasis on social context. How can we ignore the influence that the typically hyper-sexualized media and culture has on our clients and on marginalized people in general (Laverman & Skiba, 2012)? I believe we risk doing a disservice to our clients by ignoring this part of their existence. My work with female victims of domestic violence was influential in solidifying my experience and values around feminist social work practice and feminist research. While issues of power and control, the male gaze, and gender and oppression were not always made explicit in this work, these themes underscored every aspect of the work done in this area, and pushed me to look with a critical lens and work on a macro scale to target issues of inequality.

I have had ample opportunity to reflect upon my approach to the research throughout the thesis process. Without over-simplifying, the most descriptive term I feel fits with my general approach to the entire project is humility: humility in approaching the topic with an awareness of what I do not know, humility about my privilege relative to others' oppression, humility in seeking knowledge from social workers with life and professional experience, and humility in receiving guidance from those who know more than I do.

Research Methods

In this section of the Methods chapter I detail the specific methods I used in the study in three sub-sections: Participants, Procedure, and Data Analysis. It is important to mention that ethics approval was granted by the Conjoint Faculties Research Ethics Board of the University of Calgary.

Participants. Individuals were eligible for participation in the research if they were registered as social workers, had either a BSW or an MSW degree, and had (either currently or previously) a counseling role with clients. I confirmed via the Alberta College of Social Workers (ACSW) website that each participant was currently registered and therefore eligible to practice. ACSW sent the recruitment message embedded within an e-mail newsletter (Appendix A) to members in Edmonton and surrounding areas, which represented the geographic area within which I could feasibly conduct interviews. Fortunately, a reasonable number of members indicated interest and it was not necessary to expand the search for participants to Calgary or other areas in Alberta. Initially, I hoped to complete between 10-20 interviews, which I thought might be difficult to achieve due to the sensitive nature of sexuality as a topic area. However, 43 social workers responded to the request for participants. Of the 43 responses, one was ineligible as he thought he was responding to a request for a research assistant and five were disqualified as they held diplomas of social work (i.e., without a BSW or MSW). These social workers were excluded from the research as Alberta is the only province in Canada to register and professionally regulate social workers holding 2-year diplomas. To enhance the likelihood that the results of this research would be interpretable and replicable in other provinces, I did not include diploma-credentialed social workers.

I sent potential participants a follow-up e-mail (Appendix B) to secure a date and time for the interview. Attached to this e-mail was an abridged version of the interview guide (Appendix C). Several participants did not respond to this follow up e-mail, which I assumed indicated no further interest on their part. As more respondents began to indicate interest, it became clear that I would have more potential participants than I could interview. As a result, I sent an e-mail to late responders to inform them I had reached the sample size and they would not be interviewed. (Appendix D).

The sampling method I used was an availability approach. The inclusion criteria required participants hold an undergraduate or masters social work degree, which was sufficient to recruit participants able to contribute to a deep understanding of the research question. Availability sampling is suitable for generic qualitative research as the goal is not to have a sample representative of a larger population, but to explore a topic area from the perspectives of the participants. That is, generalizability is not the focus or intention; instead, credibility and exploration of the topic are paramount. The context and setting are important, and have a significant impact on what we are trying to understand (Boyatzis, 1998).

In total, the study included 14 participants with diverse backgrounds relative to a variety of demographic criteria. The participant characteristics are described fully in the Results chapter.

Procedure. I used semi-structured individual interviews to explore how participants understand and interpret human sexuality within social work. Given the sensitive nature of the topic and the amount of self-disclosure elicited during the data collection, I believed that individual interviews (as opposed to focus groups) would

maximize confidentiality and comfort for the participants. Interviewing has a number of benefits for this type of research, including affording the opportunity for participants to clarify any questions that may be ambiguous. Participants are also more likely to answer the question directly, and interpret the topic as it was intended (Marlow & Boone, 2005). Interviews are appropriate to the qualitative research methodology as the intention was to collect in-depth, rich data. Although they are time consuming, interviews were clearly the best choice for collecting this data given the topic and my ability to immerse myself in the data (Marlow & Boone, 2005).

Boyatzis (1998) emphasized the sensitivity of qualitative data, explaining that, rather than filling out a survey or questionnaire which might feel somewhat impersonal, participants are exploring the phenomenon or the attitudes in their own words, detailing their own lives through the interviews. As a result, the data are "more sensitive," which requires the researcher to be cautious and considerate regarding confidentiality and the application of study results. The importance of confidentiality within this area of research cannot be understated given that participants disclosed sensitive details of their own lives surrounding the typically taboo topic of sexuality. These disclosures included details around unplanned pregnancy and abortion, as well as sexual abuse. Almost all participants indicated that they make use of formal therapeutic counseling or an informal support person. As part of obtaining informed consent, the social worker participants were advised that they could be provided with information about free counseling if they felt upset by anything in the interview and did not identify as having a support arrangement already in place. No social workers requested information about free counseling and it can be assumed that if any were upset by the interview, they utilized

their own support networks.

The interview guide (included as Appendix C) was developed under careful supervision with my (then) thesis supervisor, and with input from my thesis cohort. The goal, to generate discussion about the central research questions, was accomplished within the interviews by following the guide but remaining open to altering questions as deemed appropriate. Following the suggestions by Rudestam and Newton (2015) regarding the construction of the interview guide, I considered the questions posed to be tools to ask the participants to dig deeper, reflect on their experiences, the meaning of these experiences, and the implications for their lives. As a feminist researcher, I was particularly interested in the participants' understanding of and critical reflection on gender and social position. I encouraged all participants to reflect upon and clarify the impact that gender has on their work with clients. I also designed probes to encourage reflections on gender, culture, religion and ethnicity to better understand the intersectionality of their personal experience with sexuality. Through careful reflection on and refinement of the interview guide, I sought to include a broad, holistic perspective on sexual health, encompassing all areas of life for the participants, including both their professional practice and personal experiences.

Initially, I proposed potential locations for interviews, at which point the participant could select the most convenient and comfortable option. Two participants were interviewed in my home office, two were interviewed in their home offices, two were interviewed at the Edmonton offices of the Faculty of Social Work, and the remainder were interviewed at their respective workplaces. Before starting the interview, informed consent was discussed and participants were asked to sign the informed consent

document (Appendix E). Each participant chose a pseudonym for confidentiality. With the permission of the participants, interviews were digitally audio-taped. All interviews were completed in May 2015, and transcription took place from May-October 2015.

The interviews themselves followed the Interview Guide (Appendix C) relatively closely, with minor changes to the questions when prompting and clarification were required. The sequence of the questions was adjusted to match the flow of each interview rather than strictly following the order in the Guide and, as a result, the style was quite conversational and comfortable. The interview questions themselves were open-ended and prompted reflection. Creswell (2014) identified a number of ethical issues that can arise in the data collection phase. I worked to mitigate against these ethical issues by adhering strictly to the Social Work Code of Ethics, completing interviews at a neutral, safe location, and obtaining informed consent, as well as making explicit the purpose of the research and my own identity as the researcher (Creswell, 2014). I also provided each participant with a small gift card ($15), not as compensation, but as a gesture of appreciation for their involvement in this study.

Data analysis. As stated previously, ethics approval was received by the University of Calgary, Conjoint Faculties Research Ethics Board, prior to the start of data collection for this study. In accordance with the expectations and the guidelines outlined in the research proposal, data have been stored with the strictest confidentiality. No identifying information has been saved on my personal computer. All digital information has been saved under the pseudonyms chosen by the participants. The only indicators of the participants' identities are the signed consent forms and one answer key matching real names to pseudonyms, written on paper and locked in a filing cabinet in my home. Since

this project captured data from only 14 participants, it was simple to memorize the pseudonyms of each through immersion in the data. I transcribed six of the 14 interviews in their entirety; a professional medical transcriptionist transcribed the rest. No confidential or identifying information was recorded on the audio files, as pseudonyms were used to protect participants' privacy. In order to manage the data collected from the interviews and to facilitate data analysis, I utilized NVivo, which is qualitative research software (Mac Version 10.2.0). In addition to NVivo's technical functions, Zamawe (2015) has claimed that using this software can help the researcher to be more creative. Following the transcription of the interviews, I used NVivo to conduct feminist-oriented Thematic Analysis.

Thematic Analysis was initially articulated by Boyatzis (1998) and further developed by Braun and Clarke (2006, 2012) and Guest, MacQueen and Namey (2012). Boyatzis (1998) explained that researchers and lay people used variations on Thematic Analysis long before it was formally identified as a data analytic approach. Though not a social worker himself, Boyatzis (1998) described applications of Thematic Analysis to substantive areas that are generally of interest to the profession. These include, for example, "identification of patterns of enabling behavior in families of alcoholics, ethnographic approaches to analysis of child rearing in various cultures, participant observation studies of street gangs" (p. vi, 1998). Thematic Analysis is appropriately applied to research in which the goal is to understand, appreciate and/or ameliorate social problems when the research does not require attachment to a particular philosophical perspective such as hermeneuetics or phenomenology. Furthermore, the Thematic Analysis approach is appropriate when a topic is being preliminarily or newly explored

based on the argument that, as Boyatzis (1998) noted, "observation precedes understanding" (p. 1). This approach to data analysis is a good fit for my research both because of its generic qualitative foundation and its exploration of a previously under-investigated topic area.

Braun and Clarke (2006, 2012) provided in-depth guidance for Thematic Analysis, which I followed quite closely. Phase One involves Familiarizing Yourself with the Data. I accomplished this phase in part by conducting all of the interviews and transcribing six of them. I also read each interview numerous times and reviewed playback of the audio recordings of the interviews.

Phase Two of Thematic Analysis is called Generating Initial Codes. Using an iterative, constant comparison process, and the NVivo software, I generated 60 initial codes. I developed a codebook (Appendix F) with definitions and explanations for each code and rules for when they would be appropriately applied. In this phase, Braun and Clarke (2012) emphasized the importance of coding to the research question rather than coding each line of text. This was made easier by the care and precision put into creating the interview guide. Also, by remaining reflective during the interviews I varied the order in which questions were asked according to the topics as they emerged. As I was interviewing, employing reflexivity helped me stay attuned to coding early in the process. Once I began analyzing the transcripts, codes began to emerge quickly as several topics were repeated across numerous interviews. Through being open to new information and approaching the raw unprocessed data, a code can emerge that has not previously been identified. Throughout the process of transcribing the interviews, I kept a research journal and made note of possible themes. However, I did not record these initial

thoughts about codes and themes on the transcriptions, preferring instead to allow the codes to be generated when I reviewed the raw data.

Phase Three of Thematic Analysis is called Searching for Themes. Themes are patterns within the data that provide the basis for organizing observations into groups, which helps to facilitate nuanced interpretation. According to Braun and Clarke (2006, 2012), moving from codes to themes is one of the most challenging aspects of the analysis because the process involves increasing levels of abstraction and interpretation. I remained responsive within this process through close supervision from my (then) supervisor and her feedback on my codebook, as well as by creating visual representations of the codes in order to organize their relationships to one another.

To complete Phase Three of the analysis, I thoroughly reviewed the codes generated in Phase Two, watching for repetition and patterns, according to the process described by Braun and Clarke (2012). It was apparent at this phase that saturation had occurred as no new insights were revealed from continued analysis of the data (Creswell, 2014). Then I moved on to phase four of Thematic Analysis, reviewing themes, and after much consideration, I crafted the themes into a visual representation (Appendix G). This visual representation was helpful during this phase but was not heavily utilized in later writing of the narrative, as the themes evolved. In the fourth phase of Thematic Analysis, Braun and Clarke suggested that the identified themes should be reviewed for fit with the data, representing an aspect of quality control. This process helped to refine and filter what became themes and what remained codes. The process of analysis allows the researcher to organize data in a way that relates to (initially) manifest themes and (subsequently) latent themes as distinguished by Boyatzis (1998). Manifest themes are

topics about which interviewees have spoken directly. Latent themes are more interpretive than manifest themes and are derived from the researcher's efforts to find patterns and relationships across interviewee comments. Manifest content may be easily observable but may neglect subtler nuances in the data and connections across interviews. On the other hand, latent themes, which involve considerable researcher interpretation, may become too complicated or distant from the experiences of the participants. The current research makes use of both manifest and latent themes, generated both inductively and deductively, at times taking advantage of concepts developed in other research and literature, but always interpreted within a feminist framework.

Pattern recognition requires immersion within the data, processing, analyzing and interpreting. In conceptualizing the meaning from the data (or identifying latent themes), the researcher must remain attentive to and transparent about the theoretical lens guiding the research. Feminism influenced my identification of both manifest and latent codes, as will become apparent in the Results chapter.

Braun and Clarke titled the fifth phase of the Thematic Analysis process "Defining and Naming Themes." At this stage, the researcher returns to the data and starts to move towards a narrative that accompanies the themes, clearly defining what does and does not entail a theme. This narrative drew heavily from my research journal and formed the first draft of the Results chapter of my thesis. In this way, the fifth and sixth phases of data analysis (Producing the Report) blended together, creating a fluid and reflective process. The focus in this sixth phase is on concisely and coherently telling the story of the participants as expressed through the data. The fifth and sixth phases were an ongoing process of writing, reading, analyzing and rewriting while being guided by my

supervisor. Given the requirements of the thesis structure, this final aspect of the data analysis is presented in the Results chapter.

Trustworthiness/Rigor

In quantitative research, the rigor of the design is evaluated through comparison with the "gold standards" of randomized controlled trials. Alternative criteria of rigor have been developed to apply to and assess feminist research. Hall and Stevens (1991) advocated that feminist researchers rely on adequacy, which seeks to ensure that the research process is meaningful, relevant and justifiable. Experts in Thematic Analysis have emphasized credibility over other ways of verifying data (Guest, MacQueen & Namey, 2012; Fereday & Muir-Cochrane, 2006). Within qualitative research, credibility and consistency are often considered important to rigor (Guest, MacQueen & Namey, 2012). Credibility refers to the confidence that one feels in the truth of the findings. Consistency refers to multiple researchers looking at the data and obtaining the same results, or to the ability to look at the data on different days and continue to see the same codes and themes illuminated (Guest, MacQueen & Namey, 2012; Fereday & Muir-Cochrane, 2006).

As discussed previously, feminist researchers are expected to use a reflective approach that helps them join in non-hierarchical relationships with their participants, and give voice to participants' experiences. Rather than testing the reliability and validity of a study, feminist research acknowledges the unique experiences of women and the interactions with their environment. Hall and Stevens (1991) suggested that the feminist researcher should be concerned with the dependability of the research process, and that rigor is pursued through systematic documentation of the study's procedures, including

data collection, rationale and communication of results. Guest, MacQueen and Namey (2012) similarly emphasized dependability and credibility over validity and reliability in qualitative research, and specifically Thematic Analysis. Dependability means that multiple researchers will come to similar conclusions when examining the same data. Credibility refers to the ability to feel confident that the findings are true to the participants' perspectives and not overly influenced by the researcher's subjectivity (Guest, MacQueen & Namey, 2012).

In the current study, the steps I took to protect trustworthiness were in keeping with qualitative and feminist orientations. During all phases of the study, and particularly during data collection and analysis, I kept a research journal, which allowed me to make connections and reflect upon the process. As Lamb (2013) pointed out, the research journal can afford "time to think about the research and make informed decisions of what was important and critical and what was not" (p. 86). This journal allowed me to identify issues to address with my supervisor, as well as reflect on challenges within the research, and the journal supported my critical thinking while illuminating observations in the data (Lamb, 2013). In addition to exercising reflexivity throughout the research process to enhance rigor, I used a number of other processes. These included regular consultation with my University of Calgary thesis cohort (both individually with other students and in small groups); maintaining a personal research journal; and regular, candid conversations with my (then) thesis supervisor. A further exploration of rigor within this research is included in the Discussion chapter.

Conclusion

Feminist researchers and social work professionals believe in and promote the value and experience of each individual. This study aimed to better understand the personal experiences and views of social workers on the topic of sexuality, as well as their situations in a sexually oppressive society. Torkelson (1996) explained this to be a strength and goal of feminist research: "There are personal, philosophical and political components to feminism" (p. 121). A feminist approach allows researchers to understand and explore problems and challenges that have largely been ignored (Eichler, 1991), including issues of sexuality. The use of a qualitative feminist approach was appropriate to the orientation and purpose of my thesis research. As described above, I made efforts throughout the process to remain reflective and mindful of the need to protect rigor. From this qualitative feminist starting place, I used semi-structured interviews with 14 people who met the criteria for the study. I used Thematic Analysis to analyze the data, thus providing strong structure to this challenging aspect of qualitative research. In the next chapter, I present the results, including a fuller description of participant characteristics and the themes uncovered from the Thematic Analysis process.

Chapter Four: Results

In this chapter, I first outline key demographic characteristics of the participants and then describe the substantive findings from the interviews. The substantive results are organized into three sections following the thematic categories. Each Thematic Category is associated with a research question as illustrated in the following table.

Table 1

Research Questions, Thematic Categories, and Themes

Research Question	Thematic Category	Themes
What are social workers' perceptions and attitudes regarding discussions of sexuality with clients?	Comfort with sexual content in clinical work	• Acceptance of self as sexual being • Having children • Sexual health education
What are social workers' practical experiences, education, and personal backgrounds in relation to therapeutic conversations about sexuality and sexual health?	"Doing good work" in the area of sex and sexuality	• Remaining transparent and inviting openness • Belief in centrality of sexuality: "It's important" • Practice improves practice • Sexuality within the social context – Structural influences – Feeling ostracized • Social work as voyeuristic
What perceptions do social workers hold about the barriers to discussing sexuality, and what are the circumstances in which they feel comfortable exploring this topic with clients?	Tools are available to decrease barriers and improve practice	Utilization of tools such as: • Boundaries, self disclosure and relationship building • Theoretical orientation and practice model • Language

As discussed in Chapter Three, Thematic Analysis (Braun & Clark, 2006) was used to analyze the data. Throughout the results, I include quotations from the participants about discussing sexuality with their clients and about the contextual factors that seem to have an impact on these discussions.

Sample Characteristics and Demographics

This analysis draws on in-depth interviews with 14 participants. The research was not intended to analyze the influence of individual variables on social workers' attitudes about sexuality. Consequently, I did not seek extensive demographic information from the participants. However, key demographic information was obtained to illustrate how applicable the data was outside the study situation. As Guest, MacQueen and Namey (2012) indicated, providing demographic information is one strategy to achieve the criterion of credibility in qualitative research (Guest, MacQueen & Namey, 2012; Lietz and Zayas, 2010). The trustworthiness, or rigor of the study, was reviewed in Chapter Three.

The participants ranged in age from 27 to 64. While the mean age was 44, participants' ages were quite varied: two were in their 20s, five in their 30s, one in their 40s, four in their 50s and two in their 60s. All participants lived and practiced social work in Edmonton, Alberta or its surrounding communities. Three participants identified as male, ten as female and one as non-binary and queer. Their reported sexual orientations were predominantly heterosexual, although one identified as queer/pansexual and two as bisexual. Nine participants identified as married in closed marriages; two indicated they are in common-law closed relationships and one in a common-law relationship currently separating; two were single; one was in an open straight marriage,

and a common law same-sex partnership. Most identified as Caucasian and Canadian; there were also participants who identified as East Indian and Hindu as well as Indigenous.

With respect to educational background, most of the participants were educated at the Master's level, holding MSW degrees. All were registered social workers in the province of Alberta; none had any current or previous disciplinary concerns with the provincial regulatory board. Only three social workers had not taken MSW degrees, and these three had attained BSW degrees. Several participants noted they had completed a bachelor's degree in psychology before completing a BSW or MSW. Several mentioned completing coursework related to human sexuality through psychology faculties before completing their social work education.

All social workers who participated in this research hold or had held paid positions with direct client interaction, most in a clinical counseling or psychotherapeutic capacity. The participants' professional backgrounds varied and, in addition to counseling, included work in or with policy, community development, the non-profit sector (inner city populations, pregnant and parenting teens, HIV intervention), children and teens, mandated and non-mandated clients, forensics, intensive mental health treatment centres, community mental health clinics, abortion clinics, employee assistance programs, hospital social work, child welfare and private practice.

As evidenced by the description of the demographic characteristics, there was considerable variation among sample participants in all areas but especially with respect to age and previous and current work experience. While hoped for but not intended, this diversity is in keeping with maximum variation sampling, through which the researcher

samples widely to ensure that typically marginalized voices are included (Flyvbjerg, 2004; Tracy, 2012). By achieving considerable diversity within this sample, the richness of the data is likely enhanced.

Participants' Comfort with Sexual Content in Social Work Practice

The first research question asked about social workers' perspectives and attitudes regarding discussions with clients about the issue of sexuality. Overall, the central theme that emerged regarding this question was that most participants reported feeling generally comfortable in these types of discussions. For example, a self-report from participant Anne says, "I'm pretty comfortable with it ... and kind of surprised how comfortable most people are with it, once you bring it up." Another participant, Anthony described his comfort level as:

> It's just as relevant as what they ate for breakfast. It's just as comfortable for us to talk… For me, it's just as comfortable for me in my training to ask that and to go down that road. That's how you learn.

Participant Fern offered the following:

> I'm okay with talking to other people about their sexuality… What does that look like? What does it feel like? It's actually one of the things that was probably a big plus of working at Planned Parenthood, the focus on positive sexuality. What does that mean? What does it look like?

Participant Mary described her sense of comfort:

> I'm pretty comfortable with it. I found that often it's something that people were really having a rough time with and didn't really know how to bring up or maybe didn't have the support of friends or family to talk about it because they felt

> embarrassed by it. So whenever it was brought up, it wasn't something that I ever felt uncomfortable about.

Varying degrees of comfort were evident across participant responses and reflections. While the participants quoted above demonstrated straightforward ease with sexuality-related conversations, ambivalence is apparent from participant Ri:

> I think I'm getting a better understanding and awareness now versus having comfort in talking about this topic before. I think even now I struggle with it because I want to be understanding and open towards it, but I don't think I have all the information to have good discussions about it.

Claire, another participant, was similarly uncomfortable. Although she explained she is a firm believer in professionalism, she also believed that being understanding of our clients is a basic tenet of social work, and that judgment and discomfort are separate concepts. She further explained that at times she feels discomfort at people's sexual choices, but maintains healthy understanding.

Below, I discuss the three sub-themes relevant to participants' comfort with sexuality in practice and their (and my) reflections on what factors may be influencing their attitudes.

Acceptance of self as a sexual being. Within the wider topic of participants' comfort with sexual content, one sub-theme pertained to participants' perceptions of their own sexual identities. Specifically, participants attributed their comfort with sexuality as a clinical topic to their acceptance and comfort with their *own* sense of sexual identity and sexuality. Participants confirmed and reiterated that their sexuality is integral to themselves as humans and to their professional practice, and that it impacts their comfort

level and attitudes in the professional domain. Anne summarized this sub-theme succinctly, stating: "if you can't talk about it in your own life, then how are you supposed to talk about other people's, as a therapist anyways." For several participants, the issue of sexual self-identity also pertained to the clinical orientation of being non-judgmental, as illustrated by a quote from Mary, who stated: "I think because I've had a pretty varied sexual experience, I think I'm really not very judgmental. I also am very aware of different ways people practice sexualities and different things people are into." Within this conceptualization, the clinician's own sexual experiences, and the type of awareness and reflection this fosters, are seen to facilitate the development of a non-judgmental attitude towards the client's sexuality.

From the results it appears that social workers who have had a wider range of sexual experience may have a greater level of comfort when discussing sexual topics with their clients. This quote from participant Anne provides support for the relationship:

> I call myself straight but there's no doubt to me that I'm more in the middle of that spectrum than I am on either end. So how does that impact how I work? …I think I'm just sort of open to the idea [that] people are who they are. And how people identify doesn't even necessarily tell you the whole picture of [what is] around their sexuality…. I have an excellent sex life. I think things are really good there and I have a great partner in terms of our relationship.

Anne went on to say that she feels comfortable talking to others about sexual topics in large part because she is comfortable doing so with her partner, with whom she can talk "about pretty much anything" sexually, including "what I do like or don't like" and what she is and is not open to.

The following quote from Anne shines light on the interplay between self-acceptance and professional comfort with sexual health:

> I was assaulted when I was 14. So I had done an awful lot of my own work around that. And so I think for me, I'm pretty comfortable. … Talking to people about really uncomfortable things, it's kind of my schtick. I really enjoy it. And so sex is just another one of those things, [as is] sexuality.

The relationship between self-acceptance and professional comfort with sexuality is also apparent in participant Anthony's words,

> I guess when you're marginalized to some degree or when you're not normal in terms of being a heterosexual or whatever, you sort of do get a lot of life experiences like I have, where you see sexism, judgement, criticism, all that sort of thing. So that does allow me to empathize. My own experiences allow me to empathize with patients. What would they know about that? I think the only thing where they would notice it is that they might feel comfortable talking to me. They might sense that there's something about this person that makes it ok to talk because I think he might understand.

These quotes suggest the likelihood that there are many "routes" social workers may take to arrive at a sense of ease about their own sexuality. Regardless of the route, however, personal acceptance figures prominently in their stories about their comfort with clients' sexuality. Providing additional evidence for the connection between self-acceptance and comfort in professional conversations were study participants who noted an opposite relationship. That is, for these participants, discussions of sexuality with clients evoked some discomfort about or lack of reflection regarding their own sexuality.

For example, in the following quote, Claire seems uneasy with sexuality-related conversations in her personal life and with clients:

> I don't think I'm really that open. I don't talk about sexuality that much personally. I don't. I don't see myself in a role personally, talking to friends, family, and certainly not patients about something that's going on for me sexually.

These results suggest that social workers who are more in tune with their own sexuality are more comfortable working with clients in this domain. This finding aligns with longstanding best-practice guidelines (Bywater & Jones, 2007). It extends the guideline by suggesting that there is not necessarily one route through which this comfort may be attained. This finding will be further examined in the Discussion chapter.

Having children. Several participants discussed the impact that having children has had on their human sexuality work with clients, and on their relative level of comfort with this topic. This sub-theme arose unexpectedly; that is, the participants were not asked about the impact of their current families or children, but were asked about their family of origin and experiences growing up. In addition to reflecting on those growing-up experiences, for example, participant Jones noted that,

> Because as a mom with young kids that's been the biggest impact actually. Sometimes I will have a flash of my kids when I'm talking to someone who has offended against children and I really have to be aware of that and then I have to receive support and supervision around that.

Jones's comment is salient for a number of reasons. First, it demonstrates this participant's reflective practice (considered in more detail in the Discussion chapter).

Furthermore, as with the first sub-theme, the quote identifies an important factor in the clinician's *personal* life that can have a significant influence on *professional* practice. Finally, it shows the fluidity of "comfort" with sexuality. It appears likely that social workers' capacity to work effectively in this area varies with life circumstances. Jones's statement suggests that, to some extent, competence may entail a self-reflective recognition of one's own "discomfort" (and intentional professional actions, like seeking supervision), rather than achieving some ideal final stage of "sexuality competence." That competence is not a permanently achieved state is in keeping with postmodern critiques of competency approaches and Edwards (2016) ideas about "intelligence," which were introduced in Chapter Three and will be further considered in the Discussion chapter.

A comment from another participant shows further complication in the issue of how social workers develop comfort and competence in sexuality-related work with clients, with a view to doing clinically skillful work (i.e., "doing good work," discussed below) in this area. The same life experience that diminished Jones's capacity to work in a practice arena enhanced participant Rosco's level of comfort. In her words, "I think it's life experience. I think, because I was a nurse before, I'm pretty comfortable with body stuff. I think having children is important; that's helped me."

Having children appears to be a major influence on social workers' practice in the area of sexuality. What is so striking about this subtheme is that it is not something that can be learned in a classroom; rather it happens organically from the lived experiences of the practitioner. The importance of the personal in the area of sexuality in social work

seems to underscore the need for clinician reflexivity. Reflexivity is a focus of the following chapter.

Sexuality education in social work. As could be predicted, given the empirical literature reviewed in Chapter Two, study participants consistently emphasized the importance of education when helping practitioners develop comfort with sexuality-related topics. For example, Fern stated,

> I really do think that there should be, at the level of the schools, a responsivity to take this on. I think one of the communication courses should be about communicating about sex, how to speak. Because the other side of it is that it's only when you do it often that you feel more comfortable. The first time you're going red, your face is turning red, you don't know if you have the right language, you're stuttering, what about this or what about that.

In addition to articulating the merits of education in the area of sexuality, Fern's quote indicates the overlap between the first and second themes (participants' comfort with sexuality and doing good work). Congruent with the literature reviewed in Chapter Two, it appears that curricula on sex and sexuality may both increase clinicians' competence and increase their comfort with sexual topics in their clinical work.

Another example of a participant suggesting that formal education was useful in helping professionals become comfortable talking about sexuality was provided by Agatha:

> I think if we would have had a full semester of how to talk about sex, some interventions, etc., you'd be way more comfortable with it. It's kind of assumed that people have sex, so they know what to do with it kind of thing, but that's not

> the case. So I think having a full semester, like three and a half months of asking about it and delving into it would probably increase the comfort level greatly.

While most participants self-identified as comfortable in discussions of sexuality, few had completed any post-secondary education related to human sexuality. Students who had completed courses related to sexuality generally evaluated them as insufficient. The following comment from Carolyn, a participant, typifies this experience:

> That class was a basic overview of…an introductory of human sexuality course, it's pretty basic stuff right? So things that I have taken since then have been much more helpful, have been more specific around you know dynamics around [sexuality].

According to the participants, education is a crucial factor for becoming comfortable with sexual topics. At the same time, most participants reported that they are personally comfortable with sexuality as a clinical topic while *also* noting that they received little or no post-secondary training in this area. Two factors may help explain this apparent contradiction. First, most participants sought additional training and professional development opportunities *after* completing their degree programs, developing this aspect of their practice through self-directed study. According to Mary, for example, "All of my competency around this has been stuff that I've deliberately sought out and learned for myself." Second, participants identified "routes" to achieve comfort in sexuality-related conversations that grew from reflection on personal experiences. Participants' emphasis on education as a key contributing factor to social workers' comfort with sexuality-related therapeutic conversations is in keeping with the extant literature. Perhaps an important and as yet unexplored area is how educators might

build on students' personal experiences related to sexuality as a scaffold to increasing personal acceptance and teaching skills in reflection. To date, asking students to bring sensitive personal material about sexuality into the classroom has often been a taboo topic area for social work. Broaching the personal/academic divide through reflectivity will be further examined in the Discussion chapter.

In addition to advocating for courses related specifically to sexuality, some participants thought attention should be directed to the general educational environment because of its potential impact on students' attitudes towards sexuality. For example, participant Lynn commented that,

> I think a huge part of it can be the school they go to. I think what professors put out there, unconsciously or consciously, impacts [attitudes]. I think if you have professors that are very open and questioning and accepting, you end up with students that come out with some of those similar ideas. If you have a school that's quite closed, and those discussions don't happen in class, I think you end up with social workers that come out of it more closed off.

Lynn's comments suggest the possibility that social work degree programs still may at tacitly support heteronormativity. Another participant's description of her experience in a social work classroom supports this interpretation. According to Mary, education about sexual orientation is "just completely lacking." As she explained,

> There were students that graduated from my class who were openly homophobic, and I really don't feel like they should be practicing social work with those beliefs, but there wasn't really a process to work with them around that and to challenge that thinking and to support them to move out of that. I really think that

> a lot of it was just that they were people who had come from maybe small towns who hadn't really ever [encountered someone who was homosexual]. I remember in one class, one of my classmates bragged that she had met "a gay." I was like "What? You met a gay?" There was two queer women in our class and they were both like, "What about us?" She hadn't even… she thought they lived with their friends. And it's like "No, they have a girlfriend that they've been with for three years." And there was no conversation around any of that. It was just really, really lacking. I mean doing the tiniest thing would be a vast improvement over what they're doing now.

Mary's account is congruent with the twofold conclusion evidenced by the literature reviewed in Chapter Two: that schools of social work are unlikely to deliver sexuality curriculum, and may not address tacit acceptance of the dominant heteronormative discourse among teachers and instructors. Participant Anthony identified students' religious motivations as an impediment to learning about sexuality, perhaps also contributing to heteronormativity, stating:

> I mean, you still get a lot of people that are really religious and they go into social work because they have this calling… you know what I mean, all this shit. They need to be stuck in a course, that's what I mean. They need to be pinned down in a mandatory course, like third or fourth year. I think it should be a course where it's not… talk about sexual orientation, talk about...

Among the participants in this research, only the social workers who completed their education outside of Alberta had human sexuality content as a mandatory component of their programs. Alberta is well-known as a politically and religiously

conservative province, which may support heteronormative perspectives and values and impact the willingness (or lack of willingness) of schools to address the topic of sexual health or provide adequate sexual health education.

Participant responses regarding how schools could incorporate sexuality in social work education were varied. Some encouraged stand-alone classes but recognized that, if optional, students who most require this training (and are least comfortable in these discussions) may deliberately avoid the class. Participants concurred that, whether the topic becomes woven into all classes or becomes a stand-alone course, schools must incorporate human sexuality into the curriculum. Two participants contextualized their responses further, noting sexuality as only one area social work programs seem to ignore. As stated by Lynn:

> I think there are a whole bunch of topics that they're inadequate around: the impact of sex, the impact of religion and spirituality, the impact of race. As much as we all talk about being anti-oppressive, I think [in] a lot of places, it's lip service.

Section conclusion. With respect to the first research question regarding social workers' experiences of sexuality-related helping, the results seemed to revolve around the concept of "comfort." Participants characterized themselves as generally comfortable, although some variation was apparent in their responses within the interviews. The participants tended to acknowledge that comfort in professional work was associated with acceptance of sexuality on the personal level. Various routes to this acceptance were identified. A personal experience that seemed to have an impact on comfort level for some participants is having a child. This finding may be most

important in how it reminds us to pay attention to the fluidity of the idea of "competence" in this practice area. Participants identified education as critical to enhancing social work competence in fields related to sexuality. However, they had received little or no sexuality course work in baccalaureate or masters social work programs and several had experienced what seemed to be homo- and trans- phobic educational environments, never mind anything approaching a "sex positive" ideal. Disturbingly, these research participants represent the sub-group of social workers with specific interest in sexuality. They have developed knowledge and skills almost in spite of their experiences in post-secondary education through extra-to-degree course work (e.g., conferences and workshops) and personal reflection.

The next section of this chapter builds on this discussion of aspects of feelings of comfort for these social workers, and explores how they conceptualize what it means to practice competently in this area and how their practice experiences may contribute to their expertise.

Doing Good Work

This section of the substantive results relates to the second research question, which focused on practice wisdom and the participants' experiences. Overall, the central theme that emerged from the data regarding this question was "doing good work." This theme had several subthemes: remaining transparent and inviting openness, recognizing the centrality of sexuality across human experience, believing that practice can improve skills, and understanding sexuality within the social context. I use quotes from the participants to discuss and exemplify the central theme, "doing going work," and each of the subthemes below.

Without specific prompting from questions on the interview guide, participants described what it means to practice well in relation to the topic of sexuality. As a theme that emerged during data analysis, "doing good work" encapsulates participants' descriptions of what it means and how to practice competently in this area. This theme also incorporates "trouble," referring to how neglecting the sexuality-related topics in practice may result in problems for the client or practitioner. These two themes – "trouble" and "doing good work" – convey the "dos and don'ts" of best practice according to the research participants.

Some participants offered their impressions of damage that may be caused by neglecting sexuality in professional practice. An example is provided by this "trouble" quote from participant Marie:

> I think when we don't have conversations, that's when we start to run into trouble. When young people or youth aren't informed, that's when I see teen pregnancy, when those conversations don't happen. … If we aren't able to ask those hard questions, then we're potentially missing a whole gamut of protection concerns and things around sexual exploitation that we could be missing.

Marie's statement is in keeping with literature that shows that ignoring clients' sexual health concerns can lead to a host of negative outcomes in mental health, relationship preferences and other important results of treatment including continued marginalization and oppression (McCave, Sheperd & Winter, 2014). Another participant, Ian, distinguished himself from social workers who do not talk about sexuality, which he considers a "fundamental" topic:

> People don't talk about money and people don't talk about sex. There are a lot of therapists who will not talk about either, and I think that if you don't talk about those things, you're missing some of the pretty fundamental [concerns]… and, yes of course, there's lots beyond that. But of the pieces that are not talked about, in my opinion, those are the two high ones. So of course I talk about them. I'm not shy.

Almost all participants gave spontaneous recommendations for social workers to enhance their work by including sexuality in practice. Participants indicated what practices they follow to ensure that care and appropriate treatment are provided. These included acquiring more education and training, developing and maintaining boundaries, utilizing appropriate self-disclosure, normalizing the issue, and being invitational/curious and transparent. Several of these strategies were brought up with such frequency that they became themes in and of themselves and will be discussed in relationship to the subsequent section focusing on tools social workers can employ in work relation to sexuality. The following quote from Mary illustrates participants' comments generally about enhancing competent practice:

> I think when we're talking about sensitive issues, we have to be very cautious to not use any judgmental language, because people remember that. And if someone feels judged at some point when they reach out for support or for counselling, they might not do it again or be really hesitant to share that piece of themselves again.

This quote is important to highlight as it draws together a number of themes that are represented in the data. The theme of "language" (discussed later in this chapter) is

brought up in relationship to the theme of "doing good work." Specifically, Mary emphasizes the impact that not "doing good work" may have on clients (feeling judged, being hesitant to share) and the longer-term impact that these practice errors may have on clients. In the following sub-sections I identify and discuss the specific components of "good work" identified by the participants.

Remaining transparent and inviting openness. Within the interviews, the concepts of "transparency" and "openness" were prominent. Conceptually, the difference between these two concepts is their focus: for interviewees, "transparency" referred to the behaviour and orientation of the clinician, whereas "openness" described the client's approach to the process. Transparency refers to being candid and easy to understand. Transparency entails a high level of openness such that the clinician is willing to answer the client's questions directly and to use self-disclosure to advance the client's progress. In the context of this research project, most participants alluded to the clinician's transparency as a clinical tool to encourage the client's openness, both to the social worker and to the clinical process. Almost all the participants (i.e., 13 of 14) mentioned "transparency" during the interview.

During the interviews, I asked each participant, "Who is more likely to bring up issues of sexuality, you or your clients?" Prior to engaging in the thesis project, I believed that social workers who are transparent and invite openness with their clients are likely to bring up issues of sexuality early in their work with clients, not waiting for the client to bring up the topic on their own. However, despite my belief and the participants' self-reports of comfort, their responses to this question varied. Four social workers indicated that clients are more likely to bring up sexuality, two indicated that it

depends on the context and seven felt it was most likely that they would be the first to bring up sexuality during the course of their work together. Agatha, who usually waits for clients to bring up sexual health issues, reflected as follows:

> Right now I'm putting [the onus] on the patient to be comfortable enough to ask, but they might be sitting there thinking that they're not going to bring it up if I don't bring it up, so if they bring it up then they're really crazy. So if I break down that wall, that might make life a bit easier for them or they might say no it's fine and then carry on; that's fine, too.

In addition to illustrating how issues of sexuality tend to come up (or not come up) in a session, this quote provides an example of how the participants engaged in reflection during the interview process itself. Within the interview, Agatha questioned her current practice. She considered an alternative and its potential impact on clients. Agatha determined that inviting the client to be open by bringing up the topic herself may increase client comfort, or, as she put it, "make life a bit easier for them." Like Agatha, my engagement in the interview process for this thesis has challenged my previous beliefs in this area such that I now try to use "intelligence" to tailor my approach to what seems to be the client's preferences.

Most of the social workers I interviewed encouraged client comfort by demonstrating transparency. Participants indicated that transparency was an important aspect of their approach to practice, and that it contributed to their comfort as well as to the client's comfort. For example, participant Ian explained, "I have very little difficulty talking about such things, and I'd like to think that I create some kind of an open, accepting environment where people feel free to talk about whatever they want to talk

about." Rosco provided a practical example of how she uses her attitude to invite clients to talk about sexuality:

> I'm pretty transparent. I'm pretty open. I think clients can take their cue from the therapist. Therapists that don't ask about that, that's not going to invite clients to ask about it. However, [you can create the right environment for openness] if you put it on the table, if you say "This is something that's really important to relationships, would you feel comfortable talking about it?" Or, "How do you think this part of your relationship is being affected by some of the other issues?"

The participants' transparency with their clients in turn invites their clients' openness. Transparency is used as a tool to increase comfort and facilitate conversation in this often sensitive area. Some participants bring up sexuality and others wait for their clients, but all participants seemed to recognize the value of demonstrating their transparency and inviting the openness of clients, as underscored in the interviews. My research participants helped me to evolve and augment my social work practice in a way that incorporates issues of human sexuality.

Recognizing the centrality of sexuality across human experience. During the interviews, all of the participants reflected on the importance of sexuality for themselves and their clients. This is in keeping with the literature in social work and allied health professions, as summarized in the literature review, that recognizes the centrality of sexuality. Anne summed up the relationship between health and sexuality: "I think you can't talk to people about being healthy without also acknowledging that they're sexual beings. Right? And that's just a part of who we are."

Identifying sexuality as an integral part of human nature allowed the social workers in this research to feel at ease in these types of discussions with clients. In much the same way that we interpret relationships as central to human experience, these social workers regard sexuality as important and approach the topic with comfort and clarity. Like Anne in the quote above, Fern acknowledged humans as sexual beings: "There is nothing that we're doing, in this whole area of social work, where it doesn't come up. We're sexual beings, we're in sexual relationships, we're in good ones or we're in bad ones." Rosco also acknowledged that she considers sexuality to be vital to human life: "Where my challenge is, or I guess what I'm thinking about is, how can somebody not explore that domain? I think people are missing a vital piece of information if they don't talk about that."

Reviewing the quotes related to this theme, I am struck by the straightforward simplicity of the participants' sentiments. These social workers consider sexuality a key contributor to overall wellness and, therefore, obviously within our scope of practice. They remark on sexuality's inclusion with a "matter of fact" attitude. Perhaps these social workers, who identify as quite comfortable with issues of sexuality, approach the topic with a clear attitude as illustrated in their quotes: this topic is of vital importance and therefore it is obvious that sexuality will be included in their work in therapeutic interactions with their clients.

Practice improves practice. Schools of social work require students to do field placements, valuing experiential learning and developing skills through practice. Any social worker may be uncomfortable the first time he or she asks a client about a sensitive topic such as drug or alcohol use, abuse history and, perhaps especially given the relative

lack of educational preparation, sexuality. Emerging from the research interviews was the theme "practice improves practice." This theme represents the understanding that while sexuality as a topic may be commonly viewed as taboo, social workers become more comfortable with the content by practicing the very discussions that some clinicians may try to avoid. As with any sensitive area, there may always be some level of discomfort. However, through preparation and practice, social workers can increase their skill and comfort level.

Quotes from the research participants help to illustrate this theme. The following statement from Marie suggests that through her practice experience her comfort and abilities have increased: "It's never a barrier for me to talk about those things. I'm pretty open. Like I said, I've seen so many things that it doesn't really bug me anymore." Mary's phrase "so many things" refers to the many and varied sexuality-related conversations she has had with clients. This supports the suggestion that practice provides opportunities to enhance skills as well as develop comfort with and positive attitudes toward a range of sexuality-related topics. Agatha described her desire to increase her comfort; in the following quote, she emphasizes the need to gain practical experience with sexuality through education and practicums:

> We never had to practice-ask "Are you feeling suicidal?" That was something you did outside of your own work, and I think some work with those tough questions would be helpful. Like "How does sex impact your relationship?" That's a tough question that you need to get used to asking.

Sexuality within the Social Context

The participants were encouraged to discuss and reflect upon their understanding of sexuality as it relates both to social work practice and more broadly to societal constructions and interpretations of sexuality. Based on their responses, the participants' understandings of sexuality and societal constructs are presented under the umbrella theme of "doing good work." These understandings relate to the research question that explores practical experiences and background, in recognition of the influence of structural factors on their lives and work. As previously stated, an additional discussion of the structural understanding of sexuality, and specifically the relationship with feminist perspectives, will be offered in the next chapter. The following subthemes are presented within this area as they relate to the messages the social workers have received about their sexuality-related work.

Structural influences. At least within Euro-Canadian culture, sexuality has become increasingly less influenced by traditional Christian values wherein, for example, premarital sex is discouraged and viewed as sinful. As discussed in the literature review, social attitudes are moving towards a more sex-positive culture. Still, the topic of sexuality remains taboo for many people; it is tacitly understood that sex and sexuality-related concerns should remain private. Participants' comments in the interviews reflected this dominant discourse regarding talk about sex, reflecting their understanding of the impact that society and its values have on their conversations with clients. The following quote from Rosco illustrates her insight into these structural and cultural discourses and how they may act as barriers to engaging with clients in discussions about sexual health:

> I don't know how many incorporate, already. But first of all, two things, what's stopping social workers from incorporating this idea? Do we feel like it's private? There's this idea certain things are private or taboo or behind-closed-doors. So we have this idea that do we even have the right? Do we even have the right to ask about this? So I think that scares some social workers away.

Almost all interview participants talked about the concept of "societal understanding of sexuality," exhibiting some understanding of how society develops and maintains sexual norms, and how these impact their practice. Some participants offered information about how they have seen the sexual health landscape change over the course of their careers or lifetimes. As Anthony explained:

> As a society about 40 years ago, we changed. Sex in culture changed quite a bit. There was a revolution I guess in the 1960s… not even the 50s, but 60s and 70s where people questioned sexuality. When I speak about our culture, I'm talking about North American culture…. I think that people took sexuality back. They personalized their sexuality within the culture.

Most participants did not offer impressions of pornography directly, but the topic did emerge in some interviews. For the most part, participants seemed to consider pornography negative and harmful. They tended to believe that, for their clients, pornography—and its availability online—has been problematic. This quote from Carolyn explains part of the evolution of society in this area and the impact on her clients:

> It's very evolving, particularly with the advent of the internet and the changing nature of views on sexuality, and that shows up a lot in my work of course and I

> get many, many families who are impacted by the internet in many different ways, kids who have a lot of knowledge about sexuality at a lot younger ages and are exposed to you know, quite deviant sexuality.

Feeling ostracized. Participants who identified feeling passionate about issues of sexuality also described feeling isolated in the social work community regarding the integration of this topic in their work with clients. Some participants even noted a tendency to be ostracized or criticized for their willingness to explore this topic with clients. The participants in this study identified as feeling generally comfortable with the topic of human sexuality. Although I was not able to interview social workers who experience significant discomfort or negative attitudes about discussing sexuality-related concerns with clients, the comments made by participants provide preliminary insight into the perspectives of these "less comfortable" social workers. The narratives gathered from the participants about this theme suggest that social workers who are uncomfortable with sexuality-related therapeutic conversations may consider the topic stigmatizing or shameful. Their response gives hints that heteronormativity may still be an accepted discourse to some extent among social workers. The following quote from Rosco shows the feedback she has received from colleagues in pursuing sexuality topics with clients: "I actually had a colleague that said, 'Why do you want to know that? That's not important, don't be a voyeur.'" A quote from Ian illustrates how he was able to respond to a colleague who remarked upon his discussions of sexuality:

> We were reviewing cases, and I talked about a client, his sexuality, and what was going on. One of my colleagues said 'People never tell me that kind of stuff,' and I said 'Well you only have to ask.

This subtheme illustrates how social workers may feel ostracized when they share with colleagues their interest in the topic of sexuality. Furthermore, it reinforces the discomfort that some social workers (perhaps many who did not respond to the recruitment for this study) have about the topic. "Not comfortable" may mean being at least somewhat accepting of heteronormative messages that can be damaging to many of the clients and client situations social workers routinely encounter in practice (as discussed in Chapter Two). These include, for example, people of sexual minority status and those who have experienced traumatic events that could have profoundly impacted their feelings about and experiences with sexuality.

Social work as voyeuristic. A number of interviewees made reference to a "voyeuristic" orientation that social workers may take in relation to sexual topics in their work. Colloquially, and in some clinical literature, "voyeurism" implies a sense of personal titillation on the part of the voyeur. However, in my opinion, the interviewees did not have this meaning in mind when they described themselves as taking a "voyeuristic" stance, never making mention of titillation or their own sexual feelings. Rather this entails building a relationship with the client, and intimately getting to know the personal details of what may be causing the biggest challenges and pain experienced by the clients in the sexual arena.

The imprecision and erotic connotation of this term illustrates the limitations of our language for discussing sexuality. A more neutral term would be more constructive. However, there are few terms that capture both: 1) the therapist's curiosity and openness to the sexual aspects of the client's life, and 2) the unique significance of sexual material per se. "Voyeurism" was seemingly chosen by the interviewees because it fulfils these

two functions, and at the same time it is problematic because it implies sexual titillation for the benefit of the "voyeur" regardless of the impact on the other. The lack of fitting language in this area may reflect societal attitudes toward sexuality. "Interest" in this topic seems to be almost automatically assumed to correlate with "voyeurism." However, unless noted otherwise, my use of the word "voyeur" below comes with the caveat that I am denoting interest without sexual titillation.

Although not explicitly examined in interview questions, opinions about voyeurism were apparent throughout the participants' responses. Some participants regarded voyeurism as problematic whereas others exhibited a perspective of voyeurism as almost helpful in discussions of sexuality. Ian described his desire to know client experience, and the commonality between himself and other social workers:

> The other thing is that I'm shameless in wanting to understand. I am a little voyeuristic, you know. I think most clinicians are a little bit of, "tell me more about that and how does that work or what is that like?" And so in many things, I would want to know more.

The following quote from Mary blends a number of the themes apparent from the interviews. Mary describes not only the impact of not discussing sexuality (trouble) but also how social workers may approach working competently in this area by asking intentional and invitational questions. She recognizes how society frames sexuality as titillating, and how, in asking about it, we risk being considered "voyeuristic" in the harmful sense of the word discussed above. Mary also appears to encourage reflective practice as she remarks:

> I think we're further stigmatizing it, and I really think that the way we ask sex workers to share their stories is… because it's kind of like sexy and titillating and interesting to listen to… it's definitely voyeuristic. So I think when asking about sex, there really needs to be like why am I asking? What am I trying to support? Not just like checkmark, what are your sexual preferences? It's like why am I asking this, what am I trying to get, and what am I trying to help?

It is apparent that societal understanding of sexuality as taboo and private continues to have an impact on therapeutic conversations related to sexuality within social work. It is likely that not all social workers are as comfortable with sexuality as the participants in this research, which may indicate that most social workers are more strongly influenced by dominant heteronormative discourses. This conclusion is supported by participants' interpretations of colleagues' judgements of their work in this area.

Section conclusion. With respect to the second research question regarding social workers' practical experiences, backgrounds, and competency in sexuality-related helping, the results seemed to revolve around the concept of what it means to "do good work" or practice with sexuality incorporated as part of what it means to practice competently in general. The participants indicated that, with respect to sexuality-related topics, they strive towards an invitational, transparent attitude with their clients, and a belief that the work is important and can be improved with practice. At the same time, they recognize how their work continues to be affected by societal norms and beliefs.

Tools Available to Decrease Barriers and Improve Practice

Barriers are factors and circumstances that impede or limit the comfort level of the social worker and/or the client in their discussions related to sexuality. This section describes barriers identified by the research participants, and how they interpret and explain these barriers in discussing sexuality with clients. This section addresses the third research question: What perceptions do social workers hold about the barriers to discussing sexuality, and what are the circumstances in which they feel comfortable exploring this topic with clients? Overall, the central theme that emerged from the interviews regarding this question is that social workers recognize there are tools available that enhance their comfort, decrease barriers, and improve practice by facilitating conversations. Quite often, barriers were defined the absence of particular facilitators. For instance, learning and using proper terminology may act as a facilitator, but feeling confused about terminology is likely to be a barrier.

Participant Fern described the genesis of barriers toward sexuality-related conversations as follows:

> I don't know whether it's still touted that social workers are supposed to be objective, and, therefore, what that means is that they can work equally well with all people, and if you can't or you're uncomfortable with this group, somehow that's something you should be working on, which I think is unadulterated crap… total stupidity. It's the wrong message. The message really should be, in my mind, that we are all products of our history, our biases, our beliefs, etc. … whatever has led us to where we are; we are here because of all of the stuff that

> comes forward. I do think that social work should be really focused in on values and beliefs and principles…without doubt.

The research participants described facilitators and barriers in multiple ways throughout the interviews. Below, I have organized their comments into three major sub-themes. First, I describe how the participants attend to boundaries with respect to sexuality-related conversations with clients. Second, I consider the possible contribution of particular practice models and theoretical orientations to social work in the area of human sexuality. Last, I consider how language can be used to support effective practice related to sexuality.

Boundaries, self-disclosure, and relationship building. Central to social work practice is the relationship. Among other skills, social workers utilize self-disclosure and maintain appropriate boundaries with clients to build relationships with them. Participants were asked in the interview about how they interpret the interplay between boundaries, self-disclosure and relationship, especially around conversations with clients involving sexuality. I wanted to explore boundaries, self-disclosure and relationship building specifically because I was curious if any of these skills could act as tools for increasing comfort in these conversations. For instance, if a gay female social worker discloses her sexual orientation to a gay female client, what impact might this have on both of their perspectives, attitudes and comfort levels? The value of self-disclosure to build relationships and pursue psychotherapeutic goals was identified by Lynn:

> [I] hope that I keep my own stuff in the background so that I can listen to what the client in front of me is saying. I definitely use self-disclosure as part of things. I have definitely used self-disclosure as [a way to tell a client] "I have no clue what

> you're talking about," or "I've never been involved in that world, thought about that, etc." The self-disclosure is both about being and not being in there.

The following quote illustrates how participant Anne begins to approach sexuality-related work by focusing attention on her boundaries*: "*Having to be very clear about boundaries is kind of important I think whenever you're having conversations about sex. For a lot of people I'll give them a preamble before I'll even ask any questions."

Pertaining to boundaries, some participants expressed concern that discussing sexuality with clients may lead to inappropriate or unprofessional discussions of a sexual nature, wherein the client may believe the social worker is interested in him or her sexually. These beliefs may impact the social worker's likelihood of engaging in conversations regarding sexuality generally. While most of the participants in this research described being comfortable facilitating therapeutic conversations about sexuality, the worry about the potential for misunderstanding may be salient among social workers who do not feel this level of comfort. Carolyn, for example, encouraged caution:

> I think you have to be very clear about [the fact that] sex with clients is not okay… I think you just have to be very clear. And … for some people talking about sex can open the door to sexual feelings. So you have to be very careful.

These participants also encouraged continual assessment within each client interaction to ascertain how much to disclose. This quote from Fern provides a valuable piece of practice wisdom about the boundaries around how much to disclose: "I think it's an individual, case by case situation how much you're disclosing with whom."

That acceptance of their own sexuality and sexual experiences may enhance social workers' comfort with sexuality-related discussions was the focus of the first section of

the results. However, that level of comfort isn't always enough to cross the line into sharing personal information with clients—at least it isn't for Marie, who connects therapist self-acceptance and self-disclosure and who is willing to share certain personal experiences:

> I have lots and lots and lots and lots of personal experience in this area that I would never bring into my practice because I think that area is too… Let's say, a kid wants to go on Depo-Provera, "Oh, it's going to kill me," or something like that. I would say "Oh well I took Depo when I was 17, and it was fine." That's something that I would maybe share, but not real … trauma-based stuff around sexuality. That would be out of my scope, and I think that it's something that would probably be pretty inappropriate. That's not something that I would ever bring up.

This quote is important in that it addresses boundaries and experience but also explores appropriate and inappropriate self-disclosure.

The participants viewed relationship-building as complementary and important to discussions about sexuality with clients. For example, Carolyn acknowledged:

> I think building rapport is important. I think how you talk about sex is important, and you don't just start with, "Oh by the way, tell me about your sex life." There are ways to ask questions that help put your question in context.

The following quote from Fern illustrates how relationship-building and boundaries are tools that are interconnected with the theme of comfort for social workers in their approach to sexual health-related content:

> [I] think part of that rapport, that establishing and maintaining a relationship is really, really important because the more comfortable I have ever been in a relationship, the easier it is to have discussions, and also to be real clear around where the lines are, the boundaries.

Participants' responses to questions about boundaries, self-disclosure and relationship-building indicated that social workers can use self-disclosure as a tool while simultaneously respecting their own and their clients' boundaries to avoid inappropriate ethics violations. The participants were aware of what is considered appropriate and knew that they were operating within the parameters of the code of ethics and standards of practice regarding sexuality. The combination of being grounded in a professional code of ethics, comfortable with their own sexuality and sexual history, and attuned to the client's sensitivities contributes to competence in this area. Jones addressed the connectivity between the elements of this subtheme of boundaries, self-disclosure, and relationship building, emphasizing how important it is to take time to build rapport, establish respect, and demonstrate that she will treat her clients fairly. She made it clear that "knowing what her role is" is critical, as is:

> knowing that I have appropriate boundaries and the questions that I ask are appropriate. Like just all those kinds of things. We give them time. They get much more comfortable over time. And it's abrasive to just ask it straight off. It ruffles people. So I just I don't.

Practice model and theoretical orientation. As reviewed in Chapter Two, the literature suggests that clinicians may be hesitant to discuss issues of sexuality with clients because they believe they lack time and competency to do so. Based on this

background "knowledge," I assumed that the practice models and theoretical orientations of the research participants would have an impact on their ability or comfort in having a dialogue about sexuality. However, even after prompting, participants did not connect their theoretical orientations with discussions they had with clients about sexuality. The participants identified the following theories and approaches as important in their practice of social work: narrative, psychodynamic, structural family therapy, emotion-focused therapy, systems theory, systemic family therapy, strength-based, eclectic and atheoretical. Two social workers also identified a strong biopsychosocial focus in their work. Despite their diverse practice approaches, all participants identified sexuality as part of their work. Only one social worker, whose theoretical orientation is psychodynamic, emphasized the impact that orientation has on a social worker's ability to include issues of sexuality in practice. This social worker explained that psychodynamic practice explores sexuality as a key component of the approach. Other participants expressed awareness that theoretical orientation may have an impact on conversations about sexuality, but did not consider this an influential factor.

In addition to theoretical orientation, I anticipated that practice models would have an impact on discussions of sexuality with clients. For instance, if the practice model dictates a maximum of four hour-long sessions with clients, the social worker may be less inclined to inquire about sexual health challenges, choosing instead to focus on the presenting concern and little else. In keeping with the literature in this area, some research participants did identify practice models as influential in their sexuality-related discussions. Claire, who works in a field related to sexuality and who typically sees her clients only once, explained the impact of practice models: "But in terms of the short-

term counseling, does it come up unless someone asks me? No it doesn't and I think that [the] limitation is time. Which sounds like an excuse." This quote is important not only for its substantive content but also because it provides an example of a participant's reflection during the interview process itself.

Fern expressed a similar belief about the relationship between the practice model and the likelihood of broaching sexuality in practice:

> I think it probably plays a huge part in terms of, if you're only going to see somebody for three sessions, and they're saying, "What I want to talk to you about is this," the question is does it really make sense to be bringing up this? I think those intense discussions around sexuality or whatever, unless the client is bringing it up, or unless it's perceived by me that it is really relevant to be talking about it.

Language: Being an ally rather than an expert. Language can be both a constraint and an inducement to therapeutic conversations related to sexuality. That is, not knowing current or colloquial terminology can be discomfiting for the client and worker but can concurrently offer an opportunity for the worker to learn from the client's knowledge. Participant Rosco shared her practice wisdom in this regard: "Language can be emotionally charged, so words can feel like a caress or a blow or a slap. So really pay attention. Some words can really sting." Another participant, Ri, spoke at length of her experience with clients teaching her useful terms and language throughout their work together, which helped her to feel comfortable and as if she had achieved a level of mastery in this area:

> My discomfort with that was just not knowing the language that she was speaking, but she made me comfortable by explaining to me what it was and explaining to me why it was important. So I think that's where it went with that, but I think that was one of the times that I felt most uncomfortable, just because I didn't know.

In this instance, the participant did not understand the terms related to sexual orientation, a situation in which many participants found themselves. Many said that young people in their practices were able to educate them about the terms related to sexual orientation and gender (for instance, transgender, pansexual, and CIS-gendered). By and large, the social workers identified this as a positive learning experience, which they approached with an invitational and curious attitude, rather than experiencing shame or embarrassment about not knowing. When I asked Fern why people feel nervous about these discussions, she said:

> That's a really good question. I don't know sometimes whether it's their own level of discomfort with their own sexuality… it's not having the correct language, it's feeling that you really should be more skilled at this than not, it's wondering what other people will say.

Finally, Ian, expressed the discomfort he felt not knowing the correct terminology when working with a young transgender woman, in addition to expressing a desire to explore the situation he noted:

> One never knows the right gender term… I guess there are still some things that still have a little bit of an edge of discomfort for me, but I'm quite willing to go past that.

Ian's statement is important because he is acknowledging that, despite his discomfort around not knowing the language, he remains willing to engage in these conversations. Social workers who affirm that sexuality is an integral part of human life can continue to competently explore these topics with clients despite some discomfort.

A postmodern approach to knowledge recognizes that there is not one single truth, and encourages us to remain on the skeptical edge of not knowing. One must wonder if it is reasonable for social workers to be taught by clients, and if social workers are responsible for having some expert knowledge in this area by virtue of education and competence. Should social workers be held accountable for doing their homework and informing themselves about the situations and circumstances that impact their clients, or is it possible to expect that clients will teach social workers? In either case, the relationship remains central to the process and a postmodern approach is upheld, an approach that questions how one can teach when nothing is certain. Holding the position of "ally" (for instance, in Gay-Straight Alliances) is widely accepted as an instance wherein the social worker can act as an advocate and support for a client but may not necessarily be in a position of expertise about the client's experience. In this "ally" position, the social worker honors and builds up the lived experience of the client and pursues the goals of anti-oppressive practice but can accept a role of not knowing, remaining in line with a postmodern approach.

Section conclusion. The third research question asked about barriers and facilitators that social workers experience related to their sexuality-related helping. As with the first two research questions, responses to this question highlighted the importance of self-knowledge and self-acceptance. Combining these with a clear

understanding of social work ethics regarding sexuality, participants maintained relationships with clients while using self-disclosure and remaining sensitive to boundaries. Factors could be identified as barriers or facilitators. The most commonly used example provided by the participants was language. Without appropriate language, comfort disappears; learning proper terminology can enhance the clinician's comfort. That these social workers (perhaps among the most knowledgeable and comfortable with sexuality in practice) were ignorant of key terms could be, at least in part, evidence of the ongoing influence of heteronormativity. That is, while these social work participants appeared comfortable and skilled discussing "sex," it might be that they were most comfortable with "normal" sex – i.e., heterosexuality. The ongoing influence of heteronormativity is considered in the Discussion chapter.

Other barriers and facilitators demonstrated in the data include the practice model in which the social worker practices; and the tools of establishing boundaries, relationship building and self-disclosure. These facets impact a social worker's willingness to engage in discussions involving topics of sexuality.

Conclusion

This chapter described the key results of this research project in three thematic areas: social workers' comfort with sexual content, "doing good work" with clients in the areas of sex and sexuality, and the barriers/facilitators to working on sexual themes with clients. Overall, the findings of this research are consistent with available data in the research literature, a congruence that will be explored in the Discussion chapter. The findings extend the literature in ways that will also be described in the final chapter.

With respect to the first theme—social workers' comfort with sexuality —the participants were generally comfortable with the topic of sex/sexuality in their clinical work. They considered training to be an important element in the process of developing competence/competency regarding sexuality; however, they also emphasized that material on sexuality is often lacking from graduate training programs in social work and may need to be sought through subsequent and supplemental study. Participants also described a number of personal factors that contribute to their comfort with discussions of sexuality. These personal factors included their own sexual experiences, personal reflection and introspection, and social factors, such as having children.

When asked about the second research question pertaining to their experiences and backgrounds in sexuality-related therapeutic practice, the theme of "doing good work" emerged. The social workers comprising the sample in this research incorporate sexuality in their practice because they consider it an essential component of competent practice. Within "doing good work," sub-themes were identified. Many participants emphasized the concept of "transparency." To achieve "good work," according to these participants, the social worker's communications about sexuality should be clear and candid. Furthermore, an attitude of curiosity was understood as acceptable and facilitative. "Openness" was identified as a skill to foster therapeutic discussions in the sexual domain. However, the commitment to openness and transparency was counterbalanced by structural obstacles to sexuality including ongoing influences from media and subtle messages from peers that sexuality should remain a taboo topic.

Relative to questions about barriers and facilitators to sexuality-related discussions in social work practice, the participants identified a number of factors. These

included practice models, relationship building, self-disclosure, setting boundaries and knowledge of correct terminology. Each can be viewed as either constraints or inducements for social workers to engage in sexuality-related helping conversations with clients. Social workers are aware that there are tools available to them that can impact how they work with these conversations.

The next and final chapter of this thesis, the discussion, will provide additional consideration of these findings in the context of existing empirical and theoretical literature, as well as implications and limitations of the study.

Chapter Five: Discussion

The purpose of this study was to investigate social workers' perspectives about sexuality and to explore the constraints and inducements that social workers experience when discussing the topic with clients. As mentioned in Chapter Four, I pick up several key areas for further discussion in this chapter including reflection, the journey towards competence, and the relationship between comfort and the sexual self. In this final chapter, I first provide a summary of the findings and consider their fit with the extant literature. I then explore the concept of reflective practice, its benefits to practice, and its relationship with the feminist, postmodern approach. I consider reflection within the participants' responses as well as my own reflective practice within the project. I explore implications of the research findings for social work practice, education, and future research. Finally, I discuss rigor relative to this qualitative research, outline the limitations of the study, and suggest possible avenues for future research.

Major Findings: Summary of the Results

This study was guided by the assumptions underlying qualitative methods generally and feminist research specifically. I interviewed 14 social workers with diverse practice backgrounds and ages, but who were predominantly female and heterosexual. Most social workers interviewed for this project identified feelings of comfort with the topic sexuality in their work with clients, and offered a number of explanations for what enhances or diminishes this sense of comfort. These explanations were explored in Chapter Four and will be expanded upon below.

It is likely that characteristics of the participants themselves had a positive impact on the quality of discussions in the interviews. Social workers embody the skills required, such as empathy and compassion, to work well with marginalized people, and

they are committed to caring for others and are internally motivated to help (MacKay & Zufferey, 2015). These strengths allowed the participants involved in this research to be willing to reflect, engage with the researcher, and offer their insights. Furthermore, it is likely the participants viewed me, the researcher as an "insider" and were willing to share accordingly. As DeShong (2013) explained, insider and outsider status is prescribed based on what aspects of the researcher's biography and experiences connect to or separate him or her from the participants. Within this research, I was an "insider" relative to all of the participants in terms of profession, and with most in terms of gender and sexual orientation.

I analyzed the data using Thematic Analysis. The following findings emerged most clearly from my participants: human sexuality is a pivotal part of human life and social workers who are comfortable with sexuality in their practice recognize its crucial role. In general, social workers comfortable with sexuality have sought out additional sexuality-related education as they believe post secondary programs do not adequately address this substantive area. Personal circumstances such as having children are likely to have an impact on attitudes as well as practice, but social workers can improve their skills and comfort level around sexuality with practice and experience. According to the participants, achieving awareness and acceptance of one's own sexual self is critically important in developing comfort and skills in this area. The participants identified a number of barriers/facilitators to effective practice related to sexuality. These included boundaries, transparency/openness, and becoming an ally.

These findings are largely consistent with the literature in social work and other helping professions, as evidenced in the literature review in Chapter Two. Compared

with this study, previous studies have had a narrower focus; for instance, investigating only sexual orientation or identity (Logie, Bridge & Bridge, 2007; Pelts, Rolbiecki & Albright, 2014), or on social work education and the inclusion of sexual health issues in curriculum (McInroy, Craig & Austin, 2014; Fredrikson et al., 2011). This thesis research asked social workers to reflect more broadly on their practical experiences as social workers dealing with sexual health issues. These broader reflections incorporated learnings from social workers around constructs like sexual orientation and education as well as attitudes, best practices, and structures that impact sexuality. Since "reflection" became such a strong theme in the study and within my own process, I discuss it more fully below.

Reflection in Research and Practice

In order to keep reflection in the forefront of my mind, I wrote the following quote at the top of my research journal: "Knowing the self is more than knowing how one feels. It is knowing how one thinks and acts" (Papell, 1969, p.11). The participants shared themselves, and their ways of knowing with me, and during the process I have been reminded of this quote and the vast knowledge that can be gained through reflection on the self and the work.

Throughout social work education, reflective practice is taught and emphasized as a key means through which clinicians can become compassionate, competent, anti-oppressive practitioners. It is my belief that throughout this research project, including analyzing the findings, the most pivotal piece of learning is the importance of reflective practice. While reflective practice was not explicitly queried within each interview, its significance was evidenced throughout the project. In this respect, the findings of the

research project were congruent with the wider literature and in social work education, which regards reflective practice as one of the most important aspects of competent practice in the helping professions.

Donald Schon's book, *The Reflective Practitioner* (1983), is viewed as the pioneering piece of literature on reflective practice and remains influential. Wilson (2013) noted that the operational definition of reflective practice is difficult to understand and hardly researched. Reflection is nonetheless recognized as extremely valuable and necessary for social workers and their clients. Additionally, Wilson's research has highlighted how schools teach and agencies encourage or discourage reflective practice, and he urged that critical thinking and reflection become integral components of the structures in which we work (2013). Reflective practice helps social workers engage in best practices, critically examine their assessments and interventions, and consider their roles in the lives of clients (Wilson, 2013).

Hermsen and Embregts (2015) asserted that reflective practice has been encouraged as a reaction to the reductionist, competency-driven approach to social work education. An alternative to the formulaic and technical-rational approach to practice that had been delivered and emphasized in education, reflective practice gained traction in the 1990s and compels social work students and professionals to regard with intention the clients, families, and systems impacting their practice, and to critically examine their own perspectives and the complexity of social issues. The fit with postmodernism is clear; reflective practice emerged as a turning away from the perspective that competency is an end result to be achieved. Reflective practice is tied closely to ethical and professional practice, increasing social workers' accountability to their clients' issues, and to what

they themselves contribute to the lives of those clients (Hermsen & Embregts, 2015). Despite a lack of consensus regarding its definition and application in clinical work, social work education programs have shifted towards promoting reflective practice in recent years, as exemplified in school curricula and a number of research and scholarly articles (Hermsen & Embregts, 2015; Ruch, 2002; Wilson, 2013).

The triangle of social work research, education, and practice is stressed by Ruch (2002). She noted the tendency to separate these areas while simultaneously recognizing the importance of keeping them connected and believed that, by operationalizing the definition of reflective practice across these three spheres, we can reimagine how they connect and better answer the question, what is reflective practice? Ruch (2002) stated:

> The essence of reflective practice involves acknowledging…the uniqueness of each situation encountered, the extraordinary complexity of human functioning whether in relation to individual personalities, family dynamics or inter-professional relations and, perhaps most pertinently, the anxiety invoked in practitioners by the work they do. (p. 202)

The model of knowledge construction I used in my thesis research is similar to reflection. In the interviews, I asked the participants to examine past experiences in a way that could inform and influence their future practice and the greater field of social work. Applied in practice, this model emphasizes the ability to learn through different channels including traditional theories, personal experience and practice wisdom, as well as intuition. Reflective practice blurs the lines of professional and personal identity and knowledge, and involves itself with self-care in that social workers are encouraged to consider how their professional experiences impact their well-being (Ruch, 2002).

Reflective practice evidenced by the research participants. In the practice of social work, reflectivity and sexuality are connected by what Ruch (2002) described as "the centrality of 'self'" (p. 200). The results of this research indicated that the sense of self is related in a significant way to how social workers approach and work with issues of sexuality. The findings suggest that, in knowing and becoming comfortable with their own sexuality, social workers enhance their comfort with the sexuality of clients. The social worker's sense of self, pivotal to reflective practice, is holistic; that is, it encompasses the emotional, spiritual, cognitive, and physical dimensions, which each incorporate sexuality. Ruch (2002) claimed that "in order for more reflective responses to be facilitated within social work practice there needs to be a re-emphasizing of the holistic nature of knowing and the valuing of 'the self'" (p. 207). By using reflective practice, social workers blend and learn from personal and professional experiences, identity and knowledge. Focusing reflection efforts on sexuality may encourage feelings of comfort and skill in client interactions. For example, Anne's quote from Chapter Four about her experience with sexual assault suggests that, by exploring their own sexual health, traumas, and desires, social workers are better prepared to practice therapeutically with these issues when they emerge with clients.

Most of the research participants appeared to experience the interview as an opportunity to reflect on practice. A number of quotes included in Chapter Four support this. The questions I posed to the participants during the interviews invited them to use a reflective lens to consider (and sometimes re-consider) their own lives and practice experiences. When I examined the interview transcripts, the participants' capacity to engage in reflection became apparent. Most participants demonstrated their reflective

skills within the interview. The few who did not offered platitudes or answered questions without giving much apparent thought to what they were saying. An example of a superficial response was one participant who offered platitudes such as "taking a lawn mower to cut off dandelions on the lawn that doesn't really solve anything." These kinds of comments both added little and appeared to lack critical reflection.

Especially relative to the participants' responses to interview questions regarding assumptions about sexuality, it was interesting to notice the frequency with which interviewees' statements began with "I think." This is an indication of the social worker's ability to reflect on his or her practice and engage in critical thought during the interview. The social workers who appeared to be engaging in reflection throughout the interview did so by asking questions aloud of themselves, as well as explaining their choices throughout the discussion. The participants demonstrated their ability to reflect by discussing and challenging their assumptions, and by disclosing the interplay between their thoughts and feelings, and professional practice. By offering these details and engaging in critical thought about their own practice and lives, the social workers were engaging in and demonstrating reflective practice.

The following quote from Marie is an example of the reflection evident in the interviews:

> There are a lot of young people today that are really challenging gender norms, and we work with a lot of them. *I think* [emphasis added] that if you're not able to understand that dynamic or understand that, it would become challenging for you, maybe.

Rosco shared and expanded on Marie's observation:

> I've worked with a number of different cultures and just my experience is that sexuality, it crosses cultures. It's something that everybody can relate to. And so, really, it's the therapist's comfort level in raising it. We have these ideas, we have these assumptions that we make that certain cultures may not feel comfortable [making]. But those, *I think* [emphasis added], are our own fear, our own discomfort. I don't *think* it happens to be that they're the client. I *think* it happens to be related to your own comfort level. If you're invitational, you can always give the client the opportunity to decline.

While it may not be possible to claim conclusively that social workers who engage in reflective practice are more comfortable or skilled in discussions of sexuality with clients, it appears that the social workers who participated in this research project did make a habit of utilizing reflective practice. This practice seems to have some influence on their understandings of human sexuality from both personal and professional perspectives as well as their comfort and skill in these discussions.

It is apparent from the results of this research, and in alignment with a postmodern approach, that there exist multiple routes towards competence in social work practice around human sexuality. Rather than a goal or state to be achieved or an end result, competence is a fluid, interactional process and a journey to be undertaken in service of the work, our clients, and ourselves. The value of this journey towards competence is well explained by Edwards' (2016) discussion of "intelligence;" its impact on practice can "further illuminate the dimensions of …the intersubjective experiences for both the client and the worker" (p. 214). These multiple routes towards competence are likely informed significantly by the reflective practice of the practitioner.

My reflective practice throughout the project. Approaching this research with a feminist, postmodern lens meant that (by default) I would be engaged in reflection throughout the project. In this section, I describe and reflect upon my experiences as practitioner, student, and researcher throughout the thesis project. I explore how sexuality intersects with various aspects of life, including my social location.

In my professional practice as a social worker, I sometimes ignore issues of sexuality in my interactions with clients. I understand that is it not a comfortable topic for many people and often I labour under the impression that clients do not expect me to explore this area of their lives with them. I am keenly aware, especially as I complete this research project, that I risk doing a disservice to my clients by avoiding discussions of sexuality, as this area of human life is important to our health and well-being (Dunk-West, Hafford-Letchfield, & Quinney, 2009; Dyer & das Nair 2013; McCave et al., 2014; Russell, 2012). The reasons for my hesitation are similar to those given by my research participants and what the literature has documented. They include my religious upbringing, feelings around my own sexuality, practice experience as a relatively new social worker, and the practice model in which I work. The ongoing process of reflecting on my own attitudes, beliefs, and feelings about sexuality and sexuality-related discussions with clients has been influential in changing the way I approach my practice, and it has also changed me as a person. In addition to increasing my attention to the heteronormative discourse and my power to influence social change, my screening and assessment of all new patients now includes a more transparent and inviting discussion of sexuality. Moreover, reflecting on my own beliefs and assumptions has helped me to

accept my relationship with sexuality in my own life, and the genesis of my desire to do this type of work.

Remaining reflective throughout this research project was key to my own development as a practitioner and feminist researcher. Extending beyond my personal and professional reflections, I also needed to reflect on my position in the knowledge creation process. Challenges faced by feminist researchers include both attending to the influence of subjectivity through reflexivity and remaining as non-hierarchical as possible while conducting research. The classic approach to research would require me to take on the researcher identity as it has been traditionally conceptualized – that is, as expert, objective observer. People who are interviewed are then relegated to the "subject" or participant role. This researcher/participant dichotomy creates a hierarchical power relationship. However, a feminist lens allows me, the researcher, to assume the importance and validate the experiences of the participants.

As discussed in Chapter Three, interviews pose some ethical challenges for researchers (Creswell, 2014). However, in their discussion of ethics in research, Brinkmann and Kvale (2005) noted the appropriateness of qualitative approaches: "researchers have recognized that when the object is concrete human experience, then qualitative methods are the most adequate means of knowledge production" (p. 162). The authors also emphasized the similarities in and differences between the research interview and therapy, a special consideration for this research given my professional identification as a social worker working in a clinical capacity. Maintaining the appropriate stance within a research interview can be difficult when wanting to achieve a depth and richness of data. This important ethical issue concerns the researchers' ability

to pick up on cues of human behavior and emotion without slipping into the role of therapist during the interview. I believe I managed this by having a well-prepared interview guide that allowed me to stay close to the planned questions while remaining empathic and open without stepping into a therapeutic role. I also used journaling to "attend to subjectivity" or "position the personal" (Deshong, 2013) in addition to trying to maintain a non-hierarchical relational stance relative to my participants during the interviews.

Implications of the Findings

A number of research projects in nursing and other allied helping professions have produced similar findings (Haboubi & Lincoln, 2003; Magnan & Reynolds, 2006; Russell, 2012; Quinn, Happell & Browne, 2011). While this study's results are comparable, they address gaps specific to the field of social work. The issues addressed in this research have rarely been so extensively investigated from a social work perspective. Whereas the findings of sexuality research from allied helping professions have usefully informed social work in the past, a positive outcome of the current research is that the implications can be explicitly directed to social work. After a discussion of the implications of the findings for social work generally, I address implications specifically for practice, education, and research.

The findings of this research support the understanding that sexuality remains a largely taboo topic, even in the field of social work, where personal topic areas are regularly approached using sensitivity and professionalism. The participants were comfortable with sexuality-related therapeutic conversations but believed that peers judged them negatively about being open to such conversations with clients. Their

willingness to discuss sexuality seems to indicate that heteronormative cultural values may be shifting to make room for sex-positive approaches supported by feminist theories. The structural beliefs and values surrounding sexuality are visible in participant responses and the themes that emerged. Participants spoke of the movement towards a sex-positive culture driven by the sexual revolution of the 1960s and beyond.

As discussed in Chapter Two, Atwood and Klucinec's (2007) feminist critique of sex therapy revealed that sexuality research generally promotes the male sexual experience to a place of importance, and results have often been generalized to the female experience; Western culture generally promotes male sexuality as the norm, according it higher value than female sexuality. Relying on the results generated from research with implicit sexist and heteronormative biases reinforces conventional understandings of sexual health, which, according to Atwood and Klucinec (2007), have "reinforced patriarchal interests and sexual double standards" (p. 35). Further, say Atwood and Klucinec (2007), "sex therapy has historically ignored social causes and solutions to sexual problems" (p. 35). This thesis research, with its mostly female participant sample, draws value from the experiences of women rather than extrapolating from the experiences of men.

The move towards social constructionism has impacted the social sciences and associated professions generally, which include sexual health theory and practice. The subjective nature of human experiences has become increasingly valued (Atwood & Klucinec, 2007). This is in keeping with the goals of this research project, which sought to gain subjective knowledge from the lived experiences of the participants rather than seeking one objective truth. Postmodernism places emphasis on the narratives that are

created through the social interpretation of language, and the social and cultural climates. In relationship to sexuality and the feminist approach, postmodernism recognizes how individuals script their sexual lives such that the meaning of a person's sexual experiences emerges and changes as social interactions shape knowledge, values, and preferences (Atwood & Klucinec, 2007).

Implications for practice. The themes that emerged from the data analysis suggest that social workers can enhance their practice related to sexuality in a number of ways. Practice can be improved through developing an open, transparent attitude toward sexuality-related therapeutic conversations, enhancing comfort level with this topic, and staying up to date regarding developments in knowledge and social mores in this area. Furthermore, the results suggest that social workers can accomplish these practice enhancements in a number of ways, which include engaging in reflective practice that encompasses their sense of sexual self, seeking out education and learning opportunities, and finding ways to practice sexuality-related conversations.

Implications of the research findings for social work practice include preliminary identification of professional competencies that could be considered by accrediting bodies such as the Canadian Association for Social Work Education. The theme in the findings related to tools available to social workers is especially useful in terms of identifying potential competencies. Social workers should remain cognizant of and attentive to their boundaries in discussions related to sexuality with their clients. They can set appropriate boundaries by using skillful self-disclosure . Self-disclosure is likely to enhance relationship building between client and worker and positively impact comfort level for both parties. Given the continuing dominance of heteronormative discourses,

social workers should have a clear understanding of the "ally" perspective and actively identify themselves as open to topics regarding sexuality, sexual health, sexual orientation, and sexual identity. At the same time, however, social workers should not extend their practice beyond their capacity and many may require additional education or professional development to challenge enduring stereotypes and hone practice skills in this area. Furthermore, social workers should be aware of specialists to whom they can refer clients requiring such advanced therapeutic support. By employing these tools, social workers are likely to enhance their practice.

Participants suggested several specific components of competent practice related to sexuality. Some social workers bring up sexuality with clients in a sensitive way by using authentic and inviting preamble, which relates back to the themes of doing good work and remaining transparent. Other practitioners stay alert to the possibility of sexuality-related conversation but wait for the client to broach the topic. Other sex-positive practice components that were encouraged by the research participants included developing and maintaining boundaries, utilizing appropriate self-disclosure, normalizing the issue, and being invitational/curious. These findings are consistent with the existing research and literature in the area of human sexuality and social work: social work should concern itself with sexuality, but at this point in time largely fails to do so (McCave et al., 2014; Dunk, 2007).

Perhaps the most important finding in this research, which holds the most significant implication for practice, is that social workers who do not incorporate sexuality into practice are doing a disservice to their clients. This finding is supported by the literature (Laverman & Skiba, 2012; McCave, Sheperd & Winter, 2014; Willert &

Semans, 2000; Woronroff, Estrada, & Sommer, 2006) and affirms the connection between various sexuality-related topics and client's health and wellbeing. As discussed in the literature review, sexuality is related to social, emotional, and physical wellbeing and vital to human life (Nyanzi, 2006; Verschuren et al., 2010; WHO, 2010). Furthermore, sexuality impacts and is impacted by broader social structures, and is likely to be encountered across diverse social work practice settings (Eubanks-Carter, Burckell, & Goldfried, 2005).

Additional insights could have been gleaned through discussing the ramifications of delaying conversations related to sexuality. In my professional practice, there have been instances wherein I did not discuss sexuality with the client in the beginning of the relationship; later when the topic arose, I was provided with information that was somewhat surprising or appeared to quickly change my assessment of the situation. It may have been beneficial to discuss what happens in practice and how the assessment of the case is affected when these types of conversations are delayed or ignored.

Implications for education. As explored in the results, social work education relating to sexuality developed as a clear theme during the data analysis. Each participant emphasized the impact that education has on enhancing comfort and attitude. Furthermore, each participant also believed that schools of social work have not incorporated this topic area in a consistent and comprehensive way despite the commitment to approach clinical problems from a holistic perspective, which by definition incorporates human sexuality. The participants felt education was a key contributor to their comfort with sexuality and encouraged schools to take on this topic in order to enhance competence for their students.

Among the significant findings of this research is that sexuality incorporates more than diversity in sexual identity. Indeed, the CASWE could enhance its standards in this regard to improve programming. Canada's social work education accrediting body should adopt criteria requiring schools of social work to include content and skill development related to sexuality. An implication of this research is the potential for informing educational practices so that social workers graduate with sexual health confidence and practice skills.

The participants in this project advocated for either stand-alone course work or interwoven sections related to human sexuality in post-secondary social work education. Overall, the implication is that we simply must change our approach to education to incorporate this crucial aspect of human life; it will prepare students to feel comfortable in these discussions and help to ameliorate negative outcomes for clients by attending to their sexual health needs.

Implications for research. The primary research-related implication of the findings from this study is the need for further social work-specific research on sexuality. As emphasized in the literature and articulated by the study participants, sexuality is an important part of human life and an important part of competent social work practice. The findings indicate that there are social workers who feel comfortable with this topic and are willing to share their practice experiences and beliefs in order to inform research in this field. The qualitative methodology was appropriate for the content area, as evidenced by the richness of the data collected. Confidential, in-depth interviews in which the participants were invited to reflect and share for as long as they liked (some for more than two hours) provided a useful conduit for understanding a sensitive topic area.

An implication for future research is that this style of knowledge development is appropriate for the exploration of a sensitive topic area like sexuality, and can help to achieve rich results. Specific directions for future research will be suggested at the end of this chapter.

Limitations of the Study

As a regular topic of therapeutic conversations, sexuality is still at least somewhat taboo. However, the social workers who participated in this study understand the importance of sexuality to individuals and their relationships and, for the most part, described themselves as comfortable having discussions about the topic with clients. When asked to speculate about how other social workers feel, and what might be impacting their comfort level, participants identified social structural discourses and beliefs about sexuality to be major inhibiting factors. The results indicate that social workers seem to be aware of the cultural and societal understandings of human sexuality and how these may impact work in this area for themselves and other social workers.

When I started this research project, I was interested in exploring diversity in social workers' comfort with, attitudes toward, and competence related to sexuality. However, the participants in this study expressed fairly similar levels of comfort, attitudes about, and expertise in sexuality-related practice and this homogeneity appears to be a limitation of the research. It may be related to how the participants were recruited, through the mailing list of the Alberta College of Social Workers. With hindsight, it is reasonable to assume that social workers who are less comfortable in sexuality-related discussions with clients would be unlikely to reply to the general call for participants.

Only two social workers explicitly identified feelings of discomfort and a lack of confidence around sexuality in their practice responded to the call for participants, and both were social workers with whom I had personal relationships. Both of these participants had completed school with me, one in the BSW program and one in the MSW program. The nature of our relationship was unlikely to bias the results in any way, as these individuals stated that they did not feel obligated to participate or to share more than was comfortable. Our researcher-participant relationship was neither enmeshed nor exploitative; rather, it was collegial in nature.

Generalizability is not a goal of qualitative research (Boyatzis, 1998; Tracy, 2010). The findings of qualitative studies are intended to give voice to participants' experiences and perceptions at a local level. Upon hearing about the participants in and results of a qualitative study, readers make decisions about the "transferability" of the findings (Tracy, 2010). When considering the transferability of this study's results, it should be kept in mind that the participants who volunteered are likely more similar to other social workers who are comfortable with sexuality-related conversations rather than they are to social workers generally. This voluntary response sample may be over-invested in the topic, neglecting those who influence and are influenced by the topic but who do not have any interest in participating in the study. To gain a sample with more heterogenous attitudes and perspectives, a purposive method may be helpful. As previously stated, one may assume that social workers not comfortable with the topic would not respond to the call for participants, despite the explicit request that social workers of all comfort levels volunteer. Some of the social workers who did participate remarked that they could recommend social workers less comfortable with the topic. One

social worker suggested a sampling strategy wherein participants who are comfortable with the subject area would be recommend colleagues who are less comfortable to participate in the research. Adopting this snowball sampling method may have produced more varied attitudes and experiences. A potential limitation on recruitment is that social workers who are not comfortable may be reluctant to admit their discomfort. Some may even be disinclined to explore their own discomfort with the topic; they may assume that social workers have some obligation to be open and able to talk about sexuality.

Feminist researchers aspire to be collaborative and non-hierarchical (Blumer, Green, Murphy & Palmanteer, 2007). This thesis project was not entirely collaborative, which is an additional study limitation. For example, given thesis regulations, it would likely be impossible to invite participants into the data analysis or report writing phases. Perhaps future research could collaborate with participants and even other researchers in more meaningful ways. Such collaboration might result in studies with more practical and persuasive results. As encouraged by the literature on feminist research, I endeavored to use the "researcher as tool" concept as a foundation of the project. While bias may be a limitation of the research, consistent communication with my thesis cohort colleagues and my research supervisor, as well as extensive journaling, have helped me to maintain a passionate but professional perspective. I was solely responsible for all interviewing, coding, and analysis. However, through consultation, reflection, transparency about my beliefs, values and biases, and continually reading more than writing, I believe I was able to maintain a feminist perspective and utilize the "researcher as tool" approach.

Rigor in Qualitative and Feminist Research

The importance of qualitative research has been underscored by Sandelowski (2004), who emphasized its practicality relative to the need "to produce knowledge that discernibly matters to someone for something" (p. 1367). She also contended that this type of research, approached from a postmodern framework, is currently held in higher esteem than in the past when it was considered "unscientific." Compared with knowledge developed from a positivist foundation, qualitatively generated knowledge is often more useful and applicable. The value of the research project can be visible when social workers are able to practically apply the tools and knowledge made apparent by the research (Sandelowski, 2004).

In quantitative methods, research rigor is evaluated through concepts such as validity, reliability, generalizability, and control. In qualitative methods, rigor has been conceptualized as related to credibility and applicability. (Guest, MacQueen & Namey, 2012). Experts in Thematic Analysis emphasize credibility and dependability over other ways of verifying rigor (Corbin & Strauss, 2008; Guest, MacQueen & Namey, 2012). If the study's findings are representative of the participants' meanings, the research is believed to be credible (Lincoln & Guba, 1985). As stated above, the researcher's goal is to provide adequate documentation for others to evaluate transferability. Generalizability is not a goal given the constructionists' emphasis on context and ever-evolving realities.

From the feminist research perspective, rigor is related to the extent to which the findings can serve social justice goals, particularly those related to women's equality. Researchers participating in feminist inquiry are expected to have a reflective approach that encourages the researcher to join in non-hierarchical relationships with their

participants, and give voice to their experiences. The recognition that "truth" from a postmodern perspective honours the lived, individualistic experience of participants runs counter to the positivist paradigm with its belief in an objective, universal reality. Rather than testing the reliability and validity of a study, feminist research acknowledges the unique experiences of women and the interactions with their environment (Hall & Stevens, 1991). Hall and Stevens (1991) have suggested that the feminist researcher should be concerned with the dependability of the research process and pursue rigor through the systematic documentation of procedures.

Rigor in this research. My efforts to establish and maintain rigor, and to promote credibility and dependability followed suggestions by Guest MacQueen and Namey (2012). These included:

1. Brainstorming, meeting with my thesis cohort (especially in the development of the research questions and interview guide), and receiving feedback.
2. Using verbatim quotes in order to be transparent in the analysis and allow for the audience to review and judge the research findings.
3. Digitally recording and then transcribing and using verbatim transcripts to allow for immersion in the data.
4. Addressing biases through critical reflection (described at length earlier in this chapter), supervision, and recognition that my own attitudes may impact how I interpret the data.

An alternative to evaluating rigor in qualitative research is presented by Tracy (2010) in her "Big-Tent" criteria, which involves eight criteria: "worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethical, meaningful coherence"

(p. 840). I believe this study meets these criteria given that worthiness is evident in the desire to address the lack of research in this field of social work, and the topic is of interest to the profession. The richness is evidenced in the quotes provided from the participants, and the depth of their reflections. Sincerity is apparent in my reflections and transparency. The ethical end goal was achieved according to Tracy's explanation of procedural, situational, relational, and exiting ethics; by receiving ethics approval from the University of Calgary Research Ethics Board; and following strict confidentiality relative to participants and data (Tracy, 2010). Additionally, the trustworthiness of the data is evidenced in my consistent use of supervision and peer consultation, the applicability of the findings to social work practice and education, and the consistency of the methods being in line with the tradition and purpose of the study (Lietz & Zayas, 2010).

Future Directions

Possibilities for future research are suggested by the findings of this study as well as by its limitations. As stated, it may be helpful, in future studies, to broaden the participant cohort to include social workers who have a wide variety of comfort levels with the topic of sexuality. As such, a snowball sampling method could be helpful. Alternatively, a quantitative approach utilizing a questionnaire could tap into participants' levels of comfort, preventing a social desirability bias and enabling respondents to be truthful and transparent. Expanding this research beyond Alberta may offer other insights. Narrowing the scope of the research would lead to more specific findings. That is, rather than asking about "sexuality" generally, it could be beneficial to select a specific element and address and explore its influence. For instance, "How does a social

worker's religion (or religious beliefs) impact his or her discussions of sexuality with clients?" Or, "How does age of the client and clinician influence the comfort level of social workers during discussions of sexuality with clients?" It may also be helpful for future research to explore the differences and compare and contrast the experiences of female, male, and trans social workers. A trend in the literature is towards a biopsychosocial model of working with sexual health issues. Although this concept was not explored in depth in this thesis, it would be an important area of focus for future research. Finally, another area of exploration could be to approach the research question from the point of view of the service users and their experiences.

Conclusion

This study was designed to help to address gaps in the literature related to sexuality in social work by exploring social workers' perspectives, attitudes, experiences, and opinions on this topic. Despite its limitations, this research project supports the claim that human sexuality is not only an important and central aspect of human nature, but it appears to be of importance to social workers. Almost all of the social workers interviewed for this thesis self-described as feeling comfortable with topics of sexual health in their work with clients, and explored the barriers or facilitators to these conversations.

The feminist perspective was used to guide to the research generally, and Thematic Analysis was implemented to analyze the data. Several key themes were presented as findings. The first theme involved participants' comfort level and included the sub-themes of sense of sexual self, having children, and social work education that focuses (or does not, as the case may be) on sexual health. The second theme provided

an explanation of what the participants consider as "doing good work" or competent practice guidelines, which encompassed the subthemes of remaining transparent and inviting openness, belief in the centrality of sexuality, practice improving practice, sexuality within the social context, and social work as voyeuristic. The last theme evident in the data pertained to the tools available to social workers that enhance competence in practice related to sexuality. These included boundaries, self-disclosure and relationship-building, the practice model, and language. One crucial aspect of this theme is the understanding that elements may act as either constraints or inducements depending on the social worker and the situation. This thesis helps to build a foundation for future research related to sexuality in social work.

The consistency of the comfort level among study participants was unexpected given that sexuality is still often considered a taboo topic. Still, the level of participants' comfort contributed to depth in the interviews and richness in the data. For me, hearing these social workers explore their experiences related to therapeutic discussions involving sexuality reaffirmed my own sexual and social work beliefs. An unanticipated personal benefit was the level of reflection this thesis inspired in me about my own work, and which improved my practice.

In conclusion, social work research has historically given little focus to the area of sexuality. What literature exists tends to reduce sexuality to little more than sexual orientation, neglecting other crucial aspects of sexual health. This thesis research was premised on a broad understanding, encouraging the participants to reflect on their own conceptualizations of sexuality from their experiences working in varied practice settings that included agencies such as Planned Parenthood and abortion clinics, and with sexual

offenders. I hope that the profession attends to the implications of this project for social work practice, education, and research. By adding to the social work discourse, these findings encourage clinicians to increase their willingness to discuss sexual health issues, and thereby to improve outcomes for clients.

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Appendix A: Recruitment Message

Your help is requested! You can contribute meaningfully to the advancement of the profession of social work by participating in this MSW thesis research project. We want to hear about your practice experience, your beliefs and your attitudes as they relate to discussions of sexuality with clients. If you are

1) a registered social worker
2) with either a BSW or an MSW
3) and have a counseling role with clients

we would like your help investigating the following research question:

What are the attitudes and perspectives of social workers regarding discussions of sexuality with clients?

Participants will be asked questions related but not limited to:

(Dis) comfort in talking about sexuality with clients,
Creating comfort and safety to talk about sexuality,
The impact of one's history, sexual and otherwise, on current comfort levels,
Barriers or facilitators to discussions regarding sexuality,
The role of social work education in preparing for discussions of sexual health with clients.

Interviews will be scheduled at a mutually convenient time and location within Edmonton or surrounding areas and will likely last 1-2 hours. Interviews will be taped and later transcribed.

If you would like more information, including the list of interview questions, please contact MSW candidate, Jane Berry, by email at jberry@ucalgary.ca .

***This Study has been approved by the University of Calgary Conjoint Faculties Research Ethics Board.**

Appendix B: Follow up email

Thank you for your interest in this research project, I'm thrilled you want to be involved!

I need to confirm that you meet the requirements of participation:

You are a registered social worker

You have a BSW or MSW

You are in a counselling role with clients (or you have been in the past). For the purpose of this research, any direct confidential contact with clients can be included towards this requirement.

Please indicate to me via email that you meet these requirements.

I'm scheduling interviews for the month of May, in the evenings and weekends. If you have professional office space, I would love to come to you and make the interview convenient. If you do not have office space, we are able to use the UofC Edmonton campus research office 11044 - 82 Avenue.

I've attached the interview guide (an abridged version for the ethics board) to this e-mail for you to take a look at. Maybe you can indicate to me some times that would work for you in May (and your preferred location). I can be available as early as 4:30 on most weekdays or any time on the weekend.

Thank you so much,

Jane Berry BSW, RSW

Appendix C: Interview Guide

Date:
Place:
Interviewer:
Interviewee (Pseudonym):

Preamble:

Thank you for agreeing to participate in this study. As you're aware, the intention of these interviews is to help answer the following research question: What are the attitudes and perspectives of social workers regarding discussions of sexuality with clients?

You will be asked details about your current and past practice, your education, your values and attitudes as well as some more personal questions about sexuality in your own life. There is a possibility that some of these questions may be triggering for you. Many people benefit from counseling. And in the event that you are triggered by something that is discussed here, do you have a formal support person you may contact? If you do not have a formal counseling arrangement, I can provide you with details for arranging counseling or debriefing as required.

The intention here is to generate honest responses in an open, non-judgmental space. Please feel free to be open and honest even if you feel embarrassed, or question your own judgement or practice. I want to collect truthful data, to generate real responses and move the field of social work forward.

This interview is being digitally recorded to allow for ease of transcription and analysis. There are no identifying factors on the digital recorder, or this protocol. Data will be stored in an encrypted, password protected file with no identifying information, on my personal computer. No one will have access to any of this data, it is to remain confidential. It is my hope you will chose a pseudonym which I can use throughout the research process. At any time you can chose to withdraw from the study. Do you understand confidentiality as it relates to this research?

Do I have your consent to proceed with the interview?

Tell me broadly about your practice- what is your practice model? Your theoretical orientation? Tell me about your case load and clientele?

For how many years have you been practicing social work?

Tell me about your educational experience.

How do you incorporate sexuality into your screening/assessment of new clients and potential interventions and therapy. Are you, or are your clients more likely to bring up issues of sexuality in session?

How integral is a discussion of sexual health to your practice?

What do you think contributes to your general attitude when it comes to talking to your clients about sex?

What do you think are contributing factors to your comfort level and skill when talking to your clients about sex? How does your own sexual orientation or experience impact your practice? What about your education? Religion/cultural/social/ethnic background? (To be inserted as probes if needed)

Tell me about a time when you were [un]comfortable talking to a client about sex

What role does Culture play in your discussions related to sexuality
What role does gender play in your discussions related to sexuality
What role does age play in your discussions related to sexuality
What role does your practice model (short term, long term, fee for service) play in your discussions related to sexuality
What role does your theoretical perspective play in your discussions related to sexuality

How does your own sexuality impact your work with clients?
How does your training around sexuality impact your practice?
What do you think would increase your comfort in regards to sexuality in session (Education?)

Tell me about a time when you've found yourself out of your comfort zone when talking about sex with clients

Tell me about a time you can look back on and feel proud about how you talked to your client about sexuality

There are times, even as anti-oppressive social workers that a person's behavior or attitudes may shock us. Tell me about a time you felt triggered by something someone said in session. Maybe you struggled to be non-judgemental. What was the judgement there? How did you negotiate it in session with your thoughts and actions?

If you had the chance to contribute anything to social work as it relates to sexuality, what would it be?

Is social work education related to sexuality adequate? If not, how would you change it if you could?

Appendix D: Email Response

Thanks for your interest in this study. Luckily, I received more than enough responses and all the spaces have been filled.

Take care and thanks again,

Jane Berry

Appendix E: Consent Form

Name of Researcher, Faculty, Department, Telephone & Email:

Researcher: Jane Berry, Faculty of Social Work,780-905-4992, Jberry@ucalgary.ca

Supervisor: Anne-Marie McLaughlin, PhD, RSW, Faculty of Social Work, 780 492 1478,

amclaugh@ucalgary.ca

Title of Project:

A Thematic Analysis of social worker's attitudes surrounding discussions of sexuality with clients.

This consent form, a copy of which has been given to you, is only part of the process of informed consent. If you want more details about something mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

The University of Calgary Conjoint Faculties Research Ethics Board has approved this research study.

Purpose of the Study

The objective of this study is to assess social worker's attitudes and perspectives regarding discussions of sexuality with their clients, using a qualitative, interview based study. Although there is a small body of research suggesting that mental health professionals in general may often be uncomfortable discussing sex and sexuality with clients, this remains an under-researched area. In particular, social workers' experiences in discussing sexuality with their clients have not yet been systematically evaluated. This research aims to address this gap in our current knowledge, by examining clinical social workers' experiences with, and

attitudes towards, discussing their clients' sexual behaviours, sexual identities, and sexual health practices.
It is hoped that this project will shed light on better ways to engage with clients around issues of sexuality. This is a qualitative research study involving 10-15 social workers available for interviews in the province of Alberta, and willing to give their time to contribute to the body of social work research.

What Will I Be Asked To Do?

Participants will be asked to complete one private interview with the researcher. Topics discussed will include human sexuality, and professional social work practice, as well as practice experiences. Interviews are scheduled for 1-2 hours, and will be audiotaped. Participants may be contacted for a follow up conversation via phone or email, only if the researcher requires clarification of any information described in the interview.

Participation is completely voluntary, you may refuse to participate altogether, may refuse to participate in parts of the study, may decline to answer any questions which make you feel uncomfortable and you may withdraw from the study at any time without penalty.

What Type of Personal Information Will Be Collected?

Some personal information will be collected, but all information will be anonymized. Should you agree to participate, you will be asked to provide your gender, age and educational background. NO personal identifying information is to be collected. (social insurance number, emails etc).

Only the primary researcher will have access to the recordings or transcriptions.

I agree to be contacted for follow-up via phone or email *Yes: ___ No: ___*

I grant permission to be audio taped: *Yes: ___ No: __*

I wish to remain anonymous, but you may choose my pseudonym: *Yes: ___ No: __*

I wish to choose my own pseudonym _____ *yes___no__*

The pseudonym I choose for myself is: _____

Are there Risks or Benefits if I Participate?

The interviews may cause some level of emotional discomfort for participants as they will be asked to recall instances in which they may have felt uncomfortable or ill-at-ease with their own skills and practice. However, it is unlikely that these interviews will cause significant distress.

If you agree to participate in this study there may or may not be a direct benefit to you, however you will have an opportunity to reflect upon your practice. The information from this study may help to provide better social work interventions to clients, and social work education for students. No financial compensation can be provided. Please be aware you can withdraw from the study at any time, without penalty.

You will not be paid for your participation. It is unlikely that you will incur any costs to participate. However, in the unlikely event that you do incur a cost (parking) you will be reimbursed.

What Happens to the Information I Provide?

Data will be reviewed thoroughly and I will remove anything that could compromise the confidentiality of the client (i.e. anecdotes that are too specific, or provide too much detail). If I uncover excellent anecdotes/case examples that put the client's anonymity in jeopardy, I will ensure the personal details are removed or changed to ensure privacy and confidentiality.

Data will be encrypted and any hard copies will be kept in a locked filing cabinet, only accessed by the researcher and her supervisor. Interview data will be examined to identify instances in which specific information may place confidentiality in jeopardy. Such instances will be redacted from the record, and omitted from all published results.

Participants are informed they can withdraw from the study at any time before data analysis, without penalty. The anonymous data will be stored for five years on a computer disk, at which time, it will be permanently erased.

Signatures

Your signature on this form indicates that 1) you understand to your satisfaction the information provided to you about your participation in this research project, and 2) you agree to participate in the research project.
In no way does this waive your legal rights nor release the investigators, sponsors, or involved institutions from their legal and professional responsibilities. You are free to withdraw from this research project at any time. You should feel free to ask for clarification or new information throughout your participation.

Participant's Name: (please print) _____

Participant's Signature: _____ Date: _____

Researcher's Name: (please print)

_____

Researcher's Signature: _____ Date:

_____

Questions/Concerns

If you have any further questions or want clarification regarding this research and/or your participation, please contact: Jane Berry, BSW, RSW (MSW Student)

jberry@ucalgary.ca
Faculty of Social Work- Edmonton Division
780-905-4992

Anne-Marie McLaughlin, PhD, RSW
Faculty of Social Work, 780 492 1478
amclaugh@ucalgary.ca

If you have any concerns about the way you've been treated as a participant, please contact the Research Ethics Analyst, Research Services Office, University of Calgary at (403) 210-9863; email cfreb@ucalgary.ca.

A copy of this consent form has been given to you to keep for your records and

reference. The investigator has kept a copy of the consent form.

Appendix F: Codebook

Age: Social worker talking about their age, specifically or in relation to clients. Do not use when talking about age of clients.

Youth: talking about work with teens, or adolescents, and their approach to sexuality.

Anti-Oppressive: Social worker referring to anti-oppressive practice (explicitly saying anti-oppressive)

Approach to practice: SW talking about their approach to practice

Asexualization: discussing asexualized groups including the elderly, the ill or disabled.

Assumptions: Wherein SW discusses assumptions (explicit)

Attitude: Describing SWer attitude

Barrier: describing the barriers to discussing sexuality, or doing good work.

Beliefs and values: swer describing or discussing their beliefs and attitudes

Biopsychosocial: swer discussing the biopsychosocial model (explicit)

Boundaries: discussing need for, importance, and implications of boundaries in sw related to sexuality

Bringing up sexuality: How social workers/clients bring up sexuality

Clients sexual health needs: what clients may need from the intervention, clinical process.

Client teaching social worker: social worker feels the client has informed their practice, skills and knowledge in the area of sexuality

Comfort: Social worker describes comfort level in talking about sexuality

Includes (CLIENT, OTHER SW & OURS)

Consultation: Social worker discusses dialogue with colleagues, what they have shared, experiences of colleagues. And the importance of this to their practice.

Cultural background: describing implications and differences in cultural background

Curious/Invitational: social workers discussing their approach including being curious and invitational in their stance

Defining sexuality: Social worker describes and defines sexuality as they see it

Doing GOOD work: what it means to the social worker to be doing GOOD work

Double standard: SW discusses double standard (gender) (explicit)

Experience: Social worker talking about their social work experience/backgrounds. Do not use when talking about specific anecdotes/stand alone experiences.

Experience- years in Practice: The more you talk about it the more comfortable you become. Getting used to talking about sex, and experience in doing so as contributing to comfort level. Use when social worker discusses becoming more comfortable with these conversations through practice.

Education: The educational experiences of sw related to sexuality (Or is this providing education to clients)

Ethnicity: Discussing ethnicity of clients/self

Fraud: SW describes feeling like a fraud

Religion: Social workers describing their religion. Use also when contrasting religion between worker and client

Gender: social worker describing or reflecting on their gender. Use also when social worker is comparing or contrasting gender in work with clients

(Also: Gender WOMEN – to use in discussing conditions/oppression specific to women)

Genesis: Use in discussing the genesis or root of the social worker's attitudes/values/beliefs

Growing up: Social worker describing their upbringing. (also how it relates to sexuality and their practice) Do not use when describing the upbringing of clients

Having kids: sw discusses having children and implications of this on practice/sexuality

Health issues as barrier: (to discussions of sexuality)

I was SW to… :Social worker sets hope or intention for social work as a whole

Impact of comfort-treatment: SW discusses the impact of comfort on the treatment

Indigenous: aboriginal or indigenous worldview/interpretations of sexuality

Integral: how sexuality seems to tie in or be integral to the swer's practice

Interview stimulation Reflection: Social worker appears to be reflecting on their practice. Use also when reflecting on their practice and the relationship between sexuality (must be quite explicit: "now that I'm talking about it")

Sense of sexual self (reflection): Social worker expresses their understanding of their own sexuality, and expresses it's importance to practice

Sex positive: Social worker brings up the concept of "sex positive".

Theoretical orientation related to sexuality: theoretical orientation is discussed in relation to sexuality

Practice model relating to sexuality: Practice model is discussed in relation to sexuality. For example: short term, long term, EAP etc

Psychoeducation: SWer discusses providing psychoeducation to clients & importance of same

Vulnerability: Social worker explores their own vulnerability, or vulnerability of the client, and it's importance to sexuality.

Interview stimulating reflection: Social worker appears to be reflecting on their practice, thinking of something differently. For example: "Good question, I hadn't thought of that before" or "maybe I need to this about this more"

Bias: social worker discusses bias

Trigger/Discomfort: social worker explores topics which cause them discomfort. For example: "Ick factor" , double standards etc.

Relating to the client: social worker discusses how they may relate to their clients, and the importance of this. For example:

Language: sw discusses importance of language ex: words can sting or blow

Relationship building: Reflection on the relationship, taking cues from therapist, need to build rapport before asking about sexuality.

Religion: differences and similarities of religion between SE/client. Impact of SW religion on practice in the area of sexuality

Self-disclosure: explore the use of, and danger of self-disclsure and their feelings and practice around same

Transparency: SW exploring their transparency and use for same, (openness, vulnerability) should be explicit.

Trauma: SW discusses their own history of trauma and it's impact on this type of work

Trouble: “Where we get in trouble” social workers reflecting on where practice “goes wrong” “doing harm”. Use with any practice issues, including boundary violations, disciplinary issues, etc.

Values: When social worker’s discuss what they value or make reference to social work inherent values.

Voyeurism: Concept of voyeurism is brought up and discussed by social worker (either in positive or negative connotations)

SW Education in sex: Use when a social worker discusses social work education around sexuality

SWers shaming others for this work: social worker describes feeling shamed by others for doing work in this field.

Taboo: This word should be made explicit in discussing nature of sexuality in order to use this code

Sex as integral in human nature: SW expresses understanding of sexuality as integral within human nature

Shame: SW brings up concept of shame

Societal understanding of sex: Speaking of cultural and societal implications of sexuality in media, western culture etc

Appendix G: Thematic Network