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Brown, M. and Dunk-West, P.

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UNIVERSITY OF Southampton
School of Social Sciences

Sexual Identities and Sexuality in Social Work

Research and Reflections from Women in the Field

Edited by

PRISCILLA DUNK-WEST
Coventry University, UK

TRISH HAFFORD-LETCHFIELD
Middlesex University, UK

chapter:
Brown, M. & Dunk-West, P.

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Chapter 4

Reflecting on Sexual Health and Young Women's Sexuality: Business or Pleasure?[1]

Michelle Brown and Priscilla Dunk-West

Introduction

The placement of pleasure within sexual health discourses is one that is problematic and often at odds with the long list of issues the sexual health worker is charged with tackling. Throughout this chapter I reflect on what gets in the way of promoting pleasure as a legitimate and sometimes political aspect to sexuality. I argue that the 'business' of sexual health is controlled by various pressures, including the need to reduce sexually transmissible infections and unplanned pregnancies. In this chapter I outline how I believe pleasure ought to fit in with the concept of sexuality as well as within educational work in sexual health. I conclude the chapter by reflecting on my professional self and how this influences the politics of my sexual health work.

The sexual health context

Sexual health is an umbrella term for organizations that provide services such as pregnancy tests, sexually transmissible infections testing, including HIV testing, as well as less 'clinical' services such as education and counselling about a range of issues related to intimacy and relationships. Although sexual health services often sit within the broad organizational context of 'health', differing professions, from medical doctors and nurses to psychologists, social workers and community workers, are employed by GUMs (genito-urinary medical clinics funded by local authorities) and non-government agencies. My experience has predominantly been working with young women both in groups as well as individually. I have, for example, provided information and support to young women accessing clinics and counselling, and through outreach settings in schools, colleges, and in the community. My roles have been varied and

1 An auto-ethnographic methodology (see Hayano 1979) was used to elicit material for this chapter. Though the chapter is co-written, the first person narrative was chosen to highlight that the material discussed is drawn from Michelle Brown's practice in sexual health.

have included health promotion, targeted support, education, peer education, information and advice, training and consultation.

Though my roles have been diverse, my work always involves talking to young women about their sexuality. Yet what sexuality means to individuals differs greatly. Defining sexuality in my work is not always an easy task, particularly since there are many definitions of this nebulous concept. I have used the following definition because of its acknowledgement that sexuality reaches beyond the mechanics of intimate interaction and because it helps the people I am working with better understand my work remit.

> Sexuality involves much more than just having sex. It is how we are distinguished as male and female, how we behave in response to physical sensations and how we interact in social relationships (Willynilly 2009).

The problem with the definition above, however, is that although it acknowledges that sexuality is about 'more than just having sex', it does not go far enough to identify various aspects to sexuality. Another of my preferred definitions of sexuality, which I use regularly in my sexual health work with young women, argues, that:

> Sexuality is a combination of people's sex, their sexual feelings for others, their feelings about themselves as sexual beings, their sexual orientation and their sexual behaviour (CYWHS undated).

Though they may appear too broad to concisely outline what sexuality entails, I have found that these definitions are good starting points to discussing young women's sexual health and sexuality, including whether these definitions make sense within their lives and experiences. The second definition contains a reference to 'sexual behaviour' and this is often the focus of sexual health campaigns such as those designed to reduce sexually transmissible infections such as Chlamydia or unplanned pregnancy. Yet, importantly, the definition also hints more at the affective dimension to sexual activity and I have found it a useful way to discuss pleasure and volition with young women.

Pleasure and pain

As I will explore throughout this chapter, in my sexual health work I promote discussion about sexual and relationship pleasure. For me, this means that young women not only reach satisfaction in their sexual relationships, but also are contented and choose, willingly, to be in their current relationships. I have worked with many young women who have disclosed that they have felt pressure either to be in a relationship or that they have been coerced into sexual activity. My view is that young women ought to expect to feel as equally entitled to pleasure and

happiness as their partners, though this is quite a simplistic stance in many ways, it can be a useful starting point in my work.

For example, the question 'will sex hurt?' is one I have been asked by young women in various settings – in group workshops, schools, and on health promotion stalls. I have always felt it important to acknowledge that young women's feelings towards their sexual partners interact in a complex way with their own lives and, as the second definition suggests, their 'feelings about themselves as sexual beings'. Yet one answer to this question might be to talk about sexual activity in a physiological sense. This would involve reporting that, generally speaking, women take longer to become sexually aroused than men (King 1997; Weiner-Davis 2004) despite men and women having similar patterns of sexual arousal and resolution over time (see Masters and Johnson 1966). Letting young women know that it is perfectly normal to need a longer period of 'foreplay' than their male sexual partners (King 1997) – because physical arousal for a woman means a greater degree of vaginal lubrication and less likelihood of pain during intercourse – is sometimes a somewhat difficult conversation to have. Mention erections, however, and the terrain seems less risqué somehow. It is telling, for example, that very few young women talk about orgasm or masturbation for themselves, and indeed often display repulsion about that region 'down there' yet readily accept that their male partners masturbate. The term 'wanker', 'tosser' or the gesture of a male masturbating, though used in popular culture as an insult, is at least ubiquitous: there is no such reference in popular culture for masturbation in women. Given this social context, is it surprising that young women's feelings about themselves as 'sexual beings' is often peppered with the assumption that men's satisfaction is the focus of sexual interaction?

One major aspect to my work is discussing communication in relationships between young people, which often involves promoting young women's sexual agency. This can be as simple as coming from the position that sexual behaviour needs to be pleasurable for both men and women. Yet given the rise in sexually transmissible infections such as Chlamydia and high unplanned pregnancy rates, sexual health work is often overcrowded with sometimes competing agendas. Add to the mix the limited time I have with young women in some of my work settings, and the question of what specifically to focus on in the limited time I have is one I rarely feel confident I have resolved. There seems to always be more work to be undertaken. Were they not to be included in sexual health, discussions of pleasure could easily be conceptualized as barriers to the 'business' of sexual health.

To return to the question being asked by young women about whether intercourse could be painful, another perhaps more medicalized approach would be to use the opportunity to focus solely on the promotion of 'safer sex' such as condom use: this would be in line with working towards reducing sexually transmissible infections and unplanned pregnancies. Yet I would argue that there is space within sexual health work to do both. Firstly, in sexual health we can take a politically oriented approach which seeks to balance out gendered inequalities in sexual behaviour and attitudes; and secondly we can still work to reduce

transmissible infections and unplanned pregnancies. This political dimension to the work both legitimizes incorporating pleasure into the core work in sexual health but also enables a critical examination of the social and individual attitudes about young women's sexuality to take place.

Offman and Matheson cite an important reason for a shift in attitudes towards women's sexual health needs. They argue that:

> Often young women's sexuality is explored not as primary, but rather as a secondary desire, that is, a response to men's sexuality (Offman and Matheson 2004:551).

Given that so much time in sexual health work is dedicated to the discussion of contraceptive choice, it is vital that considerations of 'pleasure' not only include sexual pleasure and volition but also include promoting women's agency to enjoy sexual encounters without unnecessarily being solely burdened by contraceptive responsibility. This would appear a radical undertaking since, again, the 'business' of sexual health involves educating young women about the complex and medically-oriented world of contraception.

I often wonder where is the best place to start when discussing sex and contraception with young people. Is it best to launch straight in and start off with different methods of contraception: what is available, the side effects and the associated risks of being sexually active, that is, having an unplanned pregnancy or getting a sexually transmitted infection? Although this educative approach provides young women with vital information about fertility and chemical and barrier methods to prevent pregnancy (including failure rates), is such knowledge transfer at the expense of discussions around pleasure and volition? I have found that when launching straight in with medical information I have been met with mixed reactions from young women. For example, in response to information about contraception, some tell me whether they are sexually active or not or if they are in a relationship and for how long. Tied up with such disclosures is a sense that I might be judging them; however, from my perspective it is an opportunity to model a political stance on sexual behaviour and promote pleasure-based sexual health information. Discussing relationships, for example, by separating sexual behaviour and sexual identity can help to shift dichotomous ways of thinking about same-sex attraction. Women presenting for emergency contraception, for example, are often assumed to be in heterosexual relationships when in fact they may be in same-sex relationships (Gilliam 2001). Research conducted by Eleanor Formby (2006) on lesbian and bisexual women's sexual experiences highlights the need for specific sexual health leaflets aimed at lesbian and bisexual women, or women who have sex with women, as well as relevant information about sex and relationships between women. Many women stated that they did not find it easy to find much or any relevant information about sex and relationships between women. It is important for health and educational systems to address this and to ensure that comprehensive and relevant sexual health information and education

is aimed at all young women and that it does not assume heterosexuality. Not assuming identity based on behaviour can open up new levels of discussion with young women; however balancing my own agenda with the needs of young women is an ongoing task.

Research suggests that even when young people were in possession of condoms they still chose not to use them for various reasons (Holt 2002). In response to this knowledge, I, along with a colleague, developed a targeted campaign supporting young people to develop skills in negotiating condom use. During the campaign we ran focus groups with young women. A strong theme emerged that young women were not confident in initiating a conversation about using condoms if the male had not brought it up. This was usually due to how they might be perceived, for example reporting that: 'he'd think I was easy and slept around if I said I wanted to use condoms'.

A recent survey undertaken by young people in the London Borough of Sutton (Sutton Youth Parliament 2009) asked students what they wanted to learn in Sexual and Relationship Education (SRE) as well as how they preferred to acquire knowledge in these areas. The survey legitimizes the need for sexual health education, stating that 'as young people get older they will be considering using contraception and so see it as something very important to learn about' (Sutton Youth Parliament 2009: 3). The survey findings appear to reinforce the need for a broader conceptualization of sexual health than merely a focus on reproduction and medical information. Thus, the research findings support the statement that best practice sexual health and relationship education needs to highlight the importance of relationships: 78% of young people surveyed thought that relationships are an important part of SRE; however many respondents (46%) from across the school years of 7–9 (aged 11–16) said they did not think their school highlighted the importance of relationships and felt too much emphasis was placed on biological aspects (Sutton Youth Parliament 2009: 8). A further 29% said that they did not know if their schools highlighted the importance of relationships, which may suggest that the efforts by schools to explore relationships are not effective or inadequate. Such research findings not only highlight the tension I discussed earlier in this chapter between physiological or medically-based information and the political stance of the organization or individual sexual health worker, but it also raises the question as to how much agency young people have in deciding on the agenda for sexual health work. Recent Australian research with young women argues that the notion of agency is largely 'overplayed' because it fails to take into account the social factors that impinge on the choices to be made (Baker 2008, 2010). My own approach has been to take a politically active, pleasure-focused stance in the provision of sexual health services. As we shall see, sexual health is increasingly recognizing the need for emancipatory approaches to sexuality. For example, the sexual health agency in South Australia, Sexual Health Information Networking and Education (SHine SA) argues that:

> Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. The sexual rights of all people must be respected, protected and fulfilled for sexual health to be attained and maintained (SHine SA 2005).

Not only is the inclusion of pleasure important to note in this statement, but placing sexual health needs within a rights-based framework allows for a more politicized approach to this area than their historically medically oriented counterparts. I will now outline what a rights-based approach to sexual health means to me and highlight key areas that I consider important areas for my own reflection.

Working with young women

I have spent a lot of time talking to young women about their rights when it comes to sex: the right to enjoy sex, to experience pleasure, to be safe and feel safe and respected by their partner, the right to say no, the right to want to have sex, and to feel free from judgement. Rights-based approaches to professions such as social work (for example, see Ife 2008) are equally at home with sexual health work with young women. This is because viewing sexual health provision through the lens of rights enables for a more politicized, active role than if I were to conceive of my work as merely responding to rising figures in sexually transmissible infections and unplanned pregnancies. Yet this politicized role is inextricably connected to my own selfhood: I am a young woman myself but I am also a feminist and committed to helping to create a society where women and men are equals.

Having a clear, feminist and political stance in sexual health does not always translate across into other roles. The following case study demonstrates how my actions and values in my sexual health work create a long-standing professional identity.

> After working in the same community for a number of years and having a particular focus in one secondary school, I found myself in the school in a completely different role from my sexual health role. Susan (not her real name) was a young woman I had worked with previously in my sexual health work at the school three years ago.
>
> I was leaving, Susan approached me. She told me that her friend needed to speak to me about something important. Since I knew Susan from my sexual health programme, I suspected it was related to my former role at this school. I agreed to speak to her friend Jane (not her real name). Jane told me she had had unprotected sex the previous night and was not sure what to do or where to go to get the emergency contraceptive pill. Although distressed, Jane was clear that she wanted to prevent pregnancy but she lacked information about how to go about doing this. After discussing the situation, I agreed to contact the nearby clinic and made an appointment for Jane to see a clinician. Still working under my work role as a 'general' worker in the school, I took Jane and Susan to the clinic where Jane would see a sexual health worker and receive the emergency contraceptive.

This example taken from my work made me question my role and my values, and helped me to realize how far my sexual health professional identity had become intertwined with me as a person. I had a dilemma: did I simply say that I was not at the school for sexual health work or did I respond to Susan and Jane in the same way I would if I were at work? From my interaction with Jane, I knew that if the young woman had to make her own way to the clinic, it would have been likely that she may not have made the appointment for various reasons. In the end, I responded as I would if I had been within my sexual health role. I provided Jane with the information she needed and I went with her to the clinic. It is this opportunistic and outreach work that tends to see immediate results in linking young people in with services and giving the relevant and appropriate information and support. The way I saw it, young women's needs do not neatly fit inside business hours. I could justify my response because I was not entering into a friendship with the two young women, even though I was out of work 'time'. The experience made me realize that I feel professionally and *personally* committed to my work far beyond what many workers would feel towards their work: I get pleasure from my profession because I do not merely see it within a business framework.

When I reflect on my identity as a community member and a worker in sexual health, I think I use my age and gender to help me in my work. Being a young woman working with young women has enabled me to reflect on my experiences and my friends' experiences, and for these to influence how I work and engage with young women. Often young women have said that they have preferred talking to someone younger than their parents, as they feel they will be listened to and not judged. As a young female professional, I have found many young women feel it is easy to talk to me and have said that they prefer talking to younger (if not younger looking) professionals including nurses and doctors. Age obviously influences the relationship a professional can forge with a young person, who may feel they are talking to a peer, and some young people may have difficulty understanding the professional boundaries with a younger professional. Yet some young people might not take me seriously, or think I am too young to be able to help them, or may get more easily embarrassed because of the lesser age difference. My response to this has been to enable young women to be supported to talk to as many professionals as possible, and to access information from many different sources.

Aside from my personal response in the case study above, the reported outcome is not always possible due to organizational constraints. Often it may seem that the 'systems' in place to deal with and support young people's sexual health and sexuality are in direct conflict with their actual needs. 'Systems' refers to the health system, the education system and to the smaller systems that exist within services

and organizations. I have had experience in all of them, with a strong focus on working within the education system to educate young people about sexual health. This has seemed to be quite the contentious area, with people questioning whether the delivery of sex education is appropriate in schools, or if it should happen at home by parents and not in the schooling system. I believe that young people have the right to access information and support from wherever possible and if this can happen in the school, then it can be a positive experience. However, how sexual health education is actually delivered in schools raises many concerns and issues.

To date I have not come across a uniform and compulsory curriculum delivery of comprehensive sexual health and relationships education in schools or across countries. I believe wherever it is taught, it is important that all the facts are discussed and that young people are given enough information to make choices – information which is not value laden and judgmental. This is quite difficult to achieve, but very important. Often schools dictate what is taught to students and this is dependent on the school's attitudes, values and beliefs, along with resources available and the capacity and experience of staff to deliver the information. It seems that often education systems fail to acknowledge young people's needs and 'how best to teach' particular subjects. When young people are asked who they would like to be taught sex and relationships education by, a large percentage of students would say an expert or someone outside the school, rather than their teacher or school nurse, and this fact was also acknowledged in the survey I referred to earlier conducted in secondary schools across Sutton (Sutton Youth Parliament 2009).

As I have previously highlighted in this chapter, health systems have often focussed on statistical experience rather than educational experience. In working for a national health campaign, for example, it became evident to me that the overriding focus was on the number of people involved in the programme, rather than the education and health promotion message. This potentially had an effect on how young women responded to the programme and influenced their decisions to take part in the programme. I felt that more young women would 'eventually' participate in the programme after a strong media and education campaign that focused on health promotion and education around the need for the programme; however there were very strict targets expected, with a high number of young women expected to participate each month, which reduced the amount of education and promotion conducted and achieved. I felt that often there were young women participating in the programme without a strong knowledge of what they were doing and why. This highlights how sometimes the systems in place are limited in their impact, and how the need for outcomes can often be in conflict with the most appropriate and professional ways of practice. In this particular role I felt constrained by having to always show 'outcomes' and felt that my work was not reflective of the needs of young women. After all, isn't young women's sexuality more complex than getting involved in a national health campaign for the sake of reaching a target? This complexity, along with the pressures I mentioned earlier that a young woman faces in relation to sexual health and sexuality and the multitude

of choices she must choose between, surely warrant a stronger focus than ticking a box or reaching a target.

Despite their sometimes perceived constraints and the need to reach targets, my experiences of working in and with sexual health services have generally been positive. They can provide an appropriate and professional service for young women. They are confidential, supportive, non-judgemental and flexible. Offering drop-in clinics with no need for appointments reflects their knowledge of the needs of young women, and evening and weekend clinic times additionally reflect this. I feel there is a lot of potential to improve the systems and services working with young women in relation to sexual health. Along with the challenges, however it is an ever-changing environment with new information coming to light; new contraceptive methods, new technology, and new youth cultures, all bringing with them the challenges of fitting into an organizational context in which figures legitimize service provision.

Conclusion

This reflective piece has highlighted some of the complexities inherent in my sexual health work with young women, including some of the struggles between achieving organizational targets and promoting agency in young women. I have outlined some of the barriers to the work, including social attitudes and the sometimes disjuncture between the promotion of women's pleasure and the core 'business' of sexual health. As I have argued, rights-based approaches to young women's sexualities – for example, promoting pleasure and volition – are vital values for sexual health workers to have if we are to respond to the ever shifting policies and funding of sexual health services in the coming years.

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Chapter 5

Growing up with a Lesbian or Gay Parent: Young People's Perspectives

Anna Fairtlough

Introduction

This chapter presents a qualitative content analysis of accounts, published in collected anthologies and magazines, by young people of having a lesbian or gay parent. It draws from life story approaches (Plummer 2001) and seeks to reflect young people's experiences from their own perspectives. It starts with the assumption that young people have rights to be heard and represented within research, policy and practice (Franklin 1995) and that they can provide unique and valuable insights about their lives (Alldred 1998, Lewis & Lindsay 2000). It then considers the insights that this analysis may offer to professionals working with these young people and their families, locating this within a discussion of UK policy and legislation.

Estimates of the number of children in the United States who have a lesbian or gay parent range from one to thirteen million (Stacey and Bilbarz 2001, Martin 1993). There are no reliable figures for the number of lesbian and gay parents in the UK. The second National Survey of Sexual Attitudes and Lifestyles in Britain in 2000 found that 2.6 % of both women and men reported having a same sex partner in the past five years, though many more reported having once had a same-sex sexual partner (National Centre for Social Research et al. 2005). Fish (2006) suggests that approximately one third of lesbians and 14 % of gay men have had children. However it is likely that many more are involved with parenting children in some capacity (Tasker 1999). The increasing visibility of such families in Western industrialized societies can be understood as part of wider social changes that show the traditional heterosexual family, headed by married parents taking specific and gendered roles, being supplemented by more 'diverse family forms with increasingly fluid and negotiated relationships' (Williams 2004:18). The gay and women's liberation movements have enabled new possibilities of 'doing family' to be envisaged and created (Weeks, Heaphy & Donovan 2001, Weston 1997). The heterogeneity, in relation to the social differences of gender, 'race' and class of lesbians and gay men has been noted (Patterson & Chan 1997, Fish 2006). Children with lesbian and gay parents also live in a diversity of family forms and situations. Some children were born to parents in a heterosexual relationship, with their lesbian and gay parent 'coming out' afterwards. Some are conceived