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Examining More Inclusive Approaches to Social Work, Physical Disability, and Sexuality

Shanna K. Kattari^a and George Turner^b

^aGraduate School of Social Work, University of Denver, Denver, CO, USA; ^bTurner Professional Group, Kansas City, MS, USA

ABSTRACT

People with disabilities often experience the idea that those with disabilities are not, or should not be, sexual beings. This article examines how people with physical disabilities define sexual activity, their levels of sexual satisfaction, group differences in how people define different acts as sexual activities, and the differences in levels of sexual satisfaction. Additionally, this study (N = 450) looks at the correlations between levels of independence in multiple contexts. Levels of independence are also assessed in relationship to severity of disability and sexual satisfaction. Implications for social work and social service practice, education, and policy are discussed.

KEYWORDS

Attitude change; defining sex; disability; health promotion; inclusion; people with disabilities; physical disability; sexual satisfaction; sexuality

In looking at the area of sexuality of people with disabilities, and how having a disability can affect the way the sexuality is discussed, educated on, and performed, there is a lack of information on how people with disabilities themselves view sexual activity, how different types of disabilities affect sexual satisfaction and definition of sexual activity, and the rates of sexual satisfaction among this population. Helping professionals (i.e., medical, mental health, support workers) and others who support people with disabilities (PWD) are in need of research demonstrating the effect that a disability can have on a person's experience of sexuality, and ways to aid their clients in having sexually satisfying lives.

The role that having one or more disabilities plays in identity around sexuality, as well as the effect of disability, including severity of disability and independence, on PWDs' sexual satisfaction is an area that has only seen exploration from the field of academia in the past 15 to 20 years. Shuttleworth and Sanders (2010) suggested that the body of research engaging the variety of issues connected with facilitation of sexual expression for disabled people is growing on an international level. Despite this growth, very little research exists regarding sexuality and disability, particularly on how PWD define and engage in sexual activity, and their levels of sexual satisfaction. Moreover, even less research on these topics has been conducted in the field of social

CONTACT Shanna K. Kattari, MEd, ACS, PhD candidate  shanna.kattari@du.edu  University of Denver, Graduate School of Social Work, 2148 S. High St., Denver, CO 80208, USA.

work. Additional research on this topic could support PWDs in (a) accessing culturally responsive information on sexuality from social workers and other social service professionals, (b) having more positive sexual experiences, and (c) affecting policy change around how PWD are treated regarding their sexual needs and desires.

Prevalence of disability in the United States

The U.S. Census Bureau (2012) reported that in the 2010 U.S. Census, 18.7% of all those surveyed had a disability and 12.7% had a disability designated as severe. When the numbers of older youth and adults (age 15 and older) are examined, the U.S. Census shows that 21.3% had a disability, with 14.8% of those being severe. Disabilities meeting the guidelines to be defined as severe included being deaf or blind (or unable to see, hear, or have speech understood); using a cane, crutches, or wheelchair; being unable to walk, use stairs, and carry or lift objects; needing another adult to perform activities of daily living (ADLs), and so on.

These numbers from the U.S. Census Bureau (2012) include both physical disabilities and disabilities that are emotional or cognitive (Alzheimer's, autism spectrum disorder, and other "mental or emotional conditions that seriously interfere with everyday activities"), rather than solely physical disabilities. This demonstrates that adults with disabilities make up a significant portion of the U.S. population, and that includes a large number of adults with physical disabilities. Although additional research is needed on adults living with mental and emotional conditions that could affect their experience of being sexual beings, this study focuses on those with physical disabilities, examining more specifically the nuanced differences between those with disabilities that are considered visible to others, those with disabilities that might be considered invisible to other people, and those who have both visible and invisible disabilities. As people with physical disabilities might face different challenges regarding access, stigmatization, education, and so on, based on whether these disabilities can be easily perceived by others, looking at these experiences separately allows researchers to better examine the experiences specific to each subgroup of disability.

Sexuality and disability

According to the World Association for Sexual Health's (WAS) Declaration of Sexual Rights (WAS, 2014), "Sexual rights are grounded in universal human rights" (p. 1). Furthermore, WAS stated that:

Sexuality is 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, behaviors, practices, roles, and relationships. While sexuality can include all these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the intersection of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors. (WAS, 2014, p. 1)

Knowledge about sexuality is a key component of being able to make autonomous decisions about sexual behaviors (Kattari, 2014), whether in relationship to one's sexual identity, the types of sexual activities and relationships one seeks out, or even in making choices about safer sex practices or whether or not to get pregnant. One historic study found as few as 5.0% of PWD had access to sexuality education or counseling services that supported their sexual needs (Szasz, 1991), whereas more recent research indicates that access to sex education by students with disabilities might be correlated with type of disability, with 47.5% of special education students who did not have an intellectual disability accessing sex education, whereas only 25.0% of special education students with moderate to profound disabilities able to access sex education (Barnard-Brak, Schmidt, Chesnut, Wei, & Richman, 2014). Despite this lack of access to sex education in school settings, few outside programs have been developed to support young PWD in accessing information about sexual and reproductive health (Hardoff, 2012). Not having access to education regarding sexuality and sexual health can result in PWD being at higher risk for sexually transmitted infections, sexual abuse, and unplanned pregnancies (Canadian Federation for Sexual Health, 2007). McCabe, Cummins, and Deeks (2000) found in a quantitative study about disability, sexuality, and the quality of life that "there appears to be limited opportunity for obtaining sexual knowledge or for sexual expression among people with physical disability" (p. 122). They ended with a call for further research to study the impact that society's negative view on sexuality has had on PWD and how they engage in exploring their sexuality.

In a mixed-methods study on young people with physical disabilities, more than 90% of the participants studied voiced approval for PWD to be sexually active. However, the majority of subjects showed little to no inclination toward being sexual themselves, and had a very limited view of the ways in which they might express their own sexuality (MacDougall & Morin, 1979).

Some individuals with disabilities felt that their disabilities negatively affected their sexuality and had a negative effect on their self-image and sexual self-esteem (Galvin, 2005). Other PWD found their having disabilities to be a positive influence on their sexuality and sexual expression, whereas still others had a neutral outlook on how their disabilities interplayed with their sexuality (Taleporos & McCabe, 2001). Age of individuals and the severity of their disability were not significantly correlated with sexual expression or sexual attitudes, indicating that there is no relationship between age or severity and views on PWDs' sexuality (MacDougall & Morin, 1979). However, a more

recent study found that having one or more physical disabilities is associated with having lower self-esteem about sexuality, lower levels of sexual satisfaction, and decreased frequency of sexual activity, with the impact being greater with more severe disabilities and physical impairments (McCabe & Taleporos, 2003).

Pleasure is often an absent element in conversations about disability (Turner & Crane, 2016). Whipple, Koch, Moglia, and Samuels (2003) suggested that sexual expression can benefit individuals emotionally and socially, and questioned the connections between sexual activity and spirit, whether sexual activity is in fact good for people, and even whether having sex can be considered to be therapeutic. Few studies on sexuality and disability examine sexual pleasure; Turner (2012) explored the lived experience of adults with disabilities capturing their “sexual voice.” Turner suggested that sex for pleasure is reserved almost exclusively for the nondisabled. The sexual voices of individuals with disabilities are often silenced, leaving space for stereotypes, fear, ignorance, and speculation to replace the authentic experience of this community. Not only is there a need to include pleasure as a component of sexuality research with communities of disability, but this research should also include the nuances of how sexual expression is experienced by PWD.

The negative messages society perpetuates about disability and sexuality, primarily that PWD are not or should not be sexual, can take a toll on the self-esteem of PWD (Tepper, 2000). It is possible that some of these societal assumptions are based on a lack of information and understanding about the intersections between sexuality and disability. Further research is needed to explore the experiences of PWD and how they explore and practice their sexuality to support educators, social service professionals, medical professionals, and PWD themselves in better engaging in dialogue about disability and sexuality. With further information, clinicians and community advocates will have additional resources to create change about how disability and sexuality are viewed and discussed within communities of disability, and by those working with and for these communities. One important thing these practitioners can do in supporting PWD in being sexual is help them to define and redefine what it means to be sexual (Chance, 2002).

Defining sex

Although the word *sex* is used in almost every facet of the English language, from the sex someone is assigned at birth to being used in the media as a selling point, the exact definition of sex, sexual activity, and being sexual are incredibly hard to pin down. There has been a push for several decades to redefine the mainstream heterosexual perception that sex must involve anal or vaginal penetration by a penis. One of the first movements to try and

reframe the definition of sex came from the feminist response to the HIV/AIDS crisis in which scholars suggested a move toward nonpenetrative, pleasure-centered sexual activity as a way to both support women's pleasure and limit the spread of AIDS (Kippax, Crawford, Connell, Dowsett, & Waldby, 1990; McPhillips, Braun, & Gavey, 2001; Scott, 1987).

The difficulty with defining sex continues today, with discussions on where the concept of abstinence ends and the act of having sex begins (Hamill & Chepko, 2005). Surveys of teens demonstrate a diversity of opinions, with some young people considering oral sex to be sex, whereas others consider it not to be a sex act (Remez, 2000). Despite this disparity in definitions of sex and sexual activity, many of the scales measuring sexual satisfaction fail to define the words *sex*, *sex life*, *sexual activity*, and *sexual intimacy* (Meston & Trapnell, 2005; Štulhofer, Buško, & Brouillard, 2010). Additionally, some of these measures also include a number of questions regarding the role of a partner as part of sexual satisfaction, making an assumption that an individual must have a partner (and only one partner) to be sexually satisfied (Meston & Trapnell, 2005; Štulhofer, Buško, & Brouillard, 2010).

Often discussion about sexuality can focus on the three Ds: disease, disaster, and dysfunction (McGee, 2003), which might be even more prevalent in discussions involving PWD and sexuality. This merits a narrowing of the ambiguous conversations around sexuality. The term *sexuality* was defined by the National Guidelines Task Force of the Sexuality Information and Education Council of the United States (SIECUS, 2004) as being “a natural part of being human; [it] is multifaceted, having biological, social, psychological, spiritual, ethical, and cultural dimensions” (p. 51). Furthermore, “Human sexuality encompasses the sexual knowledge, beliefs, attitudes, values, and behaviors of individuals. Its various dimensions involve the anatomy, physiology, and biochemistry of the sexual response system; identity, orientation, roles, and personality; and thoughts, feelings, and relationships. Sexuality is influenced by ethical, spiritual, cultural, and moral concerns. All persons are sexual, in the broadest sense of the word” (SIECUS, n.d., para. 2).

Three additional definitions help clarify how the term applies in this research. First, Neistadt and Freda (1987) stated:

All human beings have a need to care and be cared for ... our sexuality plays an important role in that communication process. Sexuality is the way we define ourselves as men and as women. That definition is a critical part of our self-image and can influence our interactions with others. The quality of our interpersonal relationships is, to a large extent, determined by how good we feel about ourselves as people worthy of receiving, and capable of giving, affection. Sexual activity is our most intimate way of expressing and receiving affection. Our caring and sexuality needs are not wiped out by age, illness, or disability. In fact, such changes in our life circumstances usually intensify these needs. (p. 55)

Second, Chipouras, Cornelius, Daniels, and Makas (1979) offered the following thoughts about the definition of sexuality:

Sexuality encompasses a great deal more than the physical aspects of sexual expression ... sexuality can be defined as the integration of the *physical, emotional, intellectual, and social* aspects of an individual's personality which expresses maleness or femaleness. People do not express their maleness or femaleness only in the bedroom. Sexuality is a part of all the activities in which a person engages, *work, socialization, decoration of one's home, expressing affection*. Sexuality, then, is an expression of one's personality and is evident in everyday actions. (p. 16)

Finally, Dailey (1981) offered the Circles of Sexuality model, which provides a more holistic model, avoiding the focus of other sexuality models merely on procreation. The Circles of Sexuality concept offers five distinct areas (sensuality, intimacy, identity, reproduction, and sexualization). By encouraging participants to regard sexuality according to a more comprehensive view, this model is an approach to engaging the whole person beyond solely the sexual act of intercourse, or in the case of self-advocates, in terms beyond that of the 3D model typically associated with sexuality discussions.

Research questions

Given that PWD might experience physical barriers to participating in the stereotypical, heterocentric definitions of sex, and might also be sexually active with themselves when they do not have a partner or partners, this study aims to explore how PWD define sexual activity, and whether there are differences between these definitions and between the different levels of visibility of disabilities. This study also examines whether severity of disability and levels of independence in various contexts (ADL, social activities, interpersonal relationships, and sexual relationships) are correlated with the level of sexual satisfaction.

Methods

Following approval from the university's institutional review board, an anonymous survey was created and disseminated via Qualtrics. It was sent out via Facebook, Twitter, FetLife, and Tumblr, and used snowball recruiting, asking participants to share the link with their networks as well. Participants were invited to "participate in a study examining levels of sexual satisfaction and definitions of sexual activities in people with physical disabilities. Guidelines for participation included being 18 years of age or older, and having one or more physical self-defined disabilities." The survey was conducted in English, and was checked before being sent out for compatibility with electronic readers used by those who are blind and visually impaired for increased access. The survey collected demographic information including gender identity, sexual orientation, disability type, age, education level, and

relationship status. In addition, the survey included questions on: (a) self-reported level of severity of disability, (b) self-reported level of independence in four contexts (ADL, social activities, interpersonal relationships, and sexual relationships), (c) items inquiring about a myriad of activities and whether they could be considered sexual activities, and (d) the New Sexual Satisfaction Scale (NSSS) Eco-Focused Subscale A (Štulhofer, Buško, & Brouillard, 2010).

Before analysis began, all responses for variables of interest to this study were examined for missing data. All missing data were missing at random, and were less than 10% of each variables' responses. For the variable of disability visibility (*visible*, *invisible*, *both visible and invisible*, and *other*), the category of other (1.3%, $n = 6$) was recoded as missing, so that there were only the categories of interest. Data analyses included descriptive statistics, chi-square tests of independence to determine independence in whether items were defined as sexual activity, analysis of variance (ANOVA) to compare means between different types of disabilities, and a Pearson product-moment correlation coefficient to examine correlations among severity of disability, levels of independence, and sexual satisfaction scores from the NSSS subscale.

Results

Descriptive statistics

After completing data cleaning, the sample size was 450. All participants identified as having one or more physical disabilities; 22.7% ($n = 102$) identified as having visible disabilities, 29.8% ($n = 134$) identified as having invisible disabilities, and 46.0% ($n = 207$) responded as having both visible and invisible disabilities. Racially, 83.3% ($n = 375$) identified as White, with 16.1% ($n = 71$) identifying as people of color. The average age of participants was 36.90, with a median age of 34.00. Participants ranged in age from 18 to 75. Regarding number of disabilities, participants reported having anywhere from 1 disability to 24, with the average being 2.28 and the median being 2.00. Age of onset of first disability was 27.1% ($n = 122$) at birth, 20.7% ($n = 93$) between birth and age 12, 13.6% ($n = 61$) between ages 13 and 17, 24.0% ($n = 108$) between ages 18 and 29, 12.9% ($n = 58$) between ages 30 and 49, and 1.1% ($n = 5$) at age 50 or older. For the specific racial and ethnic identities, sexual orientations, education levels, mean age, and relationship statuses of the respondents, see Table 1.

Differences in means

Levels of independence

In the ANOVA examining difference between the means of different types of disabilities, there was a significant difference between groups in reporting

Table 1. Sample description by disability.

Variable	<i>n</i>	Disability type			*
		Visible	Invisible	Both visible and invisible	
Sexual orientation	435				***
Straight/heterosexual	185	33.0%	20.5%	46.5%	
Lesbian	29	24.1%	37.9%	37.9%	
Gay	13	46.2%	23.1%	30.8%	
Bisexual	79	15.2%	35.4%	49.4%	
Queer	64	6.3%	42.2%	51.6%	
Pansexual	52	9.6%	48.1%	42.3%	
Other	13	15.4%	15.4%	69.2%	
Race	441				*
White	370	22.4%	30.8%	46.8%	
Black/African American	12	41.7%	8.3%	50.0%	
Hispanic/Latino	6	33.3%	16.7%	50.0%	
Asian/Asia Pacific Islander	5	80.0%	20.0%	0.0%	
American Indian	6	0.0%	50.0%	50.0%	
Middle Eastern	1	100.0%	0.0%	0.0%	
Biracial/multiracial	30	10.0%	40.0%	50.0%	
Other	11	27.3%	18.2%	54.5%	
Gender	442				***
Woman	288	18.1%	35.8%	46.2%	
Man	95	45.3%	9.5%	45.3%	
Trans man	14	14.3%	64.3%	21.4%	
Trans woman	4	0.0%	25.0%	75.0%	
Genderqueer	29	13.8%	24.1%	62.1%	
Other	12	0.0%	41.7%	58.3%	
Education level	443				—
Some high school	7	14.3%	0.0%	85.7%	
High school diploma/GED	22	27.3%	22.7%	50.0%	
Some college/tech	100	19.0%	33.0%	48.0%	
Associate's degree	43	20.9%	32.6%	46.5%	
Bachelor's degree	135	22.2%	34.8%	43.0%	
Master's degree	99	28.3%	28.3%	43.4%	
Doctoral degree	37	24.3%	18.9%	56.8%	
Relationship status					**
Single	106	34.0%	18.9%	47.2%	
Casually dating	21	19.0%	33.3%	47.6%	
Partnered (1 partner)	206	20.9%	38.3%	40.8%	
Partnered (multiple partners)	65	10.8%	33.8%	55.4%	
Widowed	7	0.0%	14.3%	85.7%	
Divorced	10	20.0%	20.0%	60.0%	
Other	27	33.3%	11.1%	55.6%	
Age (<i>M</i>)	433	36.63	33.85	39.03	***
Severity of disability (<i>M</i>)	438	5.72	5.46	5.90	—
New Sexual Satisfaction Scale average	413	3.78	3.40	3.52	

* $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

self-identified level of independence in social activities, $F(2, 437) = 5.37$, $p < .01$, and in reporting self-identified level of independence in interpersonal relationships, $F(2, 437) = 3.07$, $p < .05$ (see Table 2). Homogeneity of variance was not significant for either independence of social activities or independence of interpersonal relationships. Using a Tukey's post-hoc test, there is a significant difference between the means of those with visible and invisible

Table 2. Levels of independence and sexual satisfaction by disability.

Variable	n	Visible	Disability type		*
			Invisible	Both visible and invisible	
Level of independence in activities of daily living (M)	437	7.44	7.50	6.93	—
Level of independence in social activities (M)	437	7.68	6.76	6.76	**
Level of independence in interpersonal relationships (M)	437	7.93	7.25	7.26	*
Level of independence in sexual relationships (M)	437	7.52	7.32	7.01	—
Average of New Sexual Satisfaction Scale items	410	3.78	3.40	3.52	*

* $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

disabilities, and between participants with visible disabilities and those with both visible and invisible disabilities for social activities. For independence of interpersonal relationships, a Tukey's post-hoc test did not indicate a significant difference between group means. There were no significant differences between group means for self-reported severity of disability (as shown in Table 1), self-identified level of independence in ADL, or self-identified level of independence in sexual relationships.

Sexual satisfaction scores between types of disability

In the ANOVA examining difference between the means of different types of disabilities, there was a significant difference between group means in the average response to items on the NSSS, $F(2, 410) = 3.57$, $p < .05$. Homogeneity of variance was not significant, and a Tukey's post-hoc test revealed a significant difference between the means of those with visible and invisible disabilities. There was no significant difference between those with visible disabilities and those who had both invisible and invisible disabilities, nor between those with visible disabilities and those with both invisible and visible disabilities.

Correlation

Levels of independence

A Pearson product-moment correlation coefficient was computed to assess the relationships between severity of disability, the different measures of independence that were self-reported, and the average ratings of the NSSS. Severity of disability was significantly negatively correlated with level of independence of daily activities, $r(445) = -.20$, $p \leq .001$; level of independence in social activities, $r(445) = -.17$, $p \leq .001$; level of independence of interpersonal relationships, $r(445) = -.15$, $p \leq .001$; and level of independence in sexual relationships, $r(445) = -.16$, $p \leq .001$. This indicates that the higher the

Table 3. Percentage responding “yes” to indicate that an item is a sexual activity, by disability.

Variable	n	Disability type			*
		Visible	Invisible	Both visible and invisible	
Masturbation (solo)	435	61.0%	75.8%	78.8%	**
Masturbation (with partner)	437	76.0%	92.4%	88.8%	**
Kissing	439	40.4%	36.8%	46.9%	—
Fondling (over clothes)	437	66.3%	66.2%	70.4%	—
Cuddling	432	31.3%	27.1%	32.0%	—
Rubbing/frottage/scissoring	432	68.0%	85.4%	87.1%	**
Fingering/manual stimulation/hand jobs	439	83.0%	98.5%	94.7%	***
Oral sex (on penis, vulva, anus, or toy)	439	92.9%	98.5%	95.7%	—
Vaginal penetration (w/toy or penis)	436	90.0%	98.5%	96.6%	**
Anal penetration (w/toy or penis)	432	82.8%	96.9%	94.1%	***
Other use of sex toys with partner	434	73.7%	94.7%	89.2%	***
Spanking/flogging/whipping	428	51.5%	66.2%	56.7%	—
Power exchange/dominance/submission	429	50.5%	64.6%	55.9%	—
Reading erotica (alone)	432	24.7%	33.3%	37.9%	—
Reading erotica (with partner)	429	32.7%	43.9%	46.7%	*
Watching porn/adult videos (alone)	428	37.1%	41.5%	46.3%	**
Watching porn/adult videos (with partner)	429	43.3%	50.8%	58.9%	**
Phone sex (texting or talking)	425	53.1%	57.7%	49.2%	—
Internet sex (chat rooms, emails, cams)	426	48.0%	56.6%	46.7%	—

* $p \leq .05$. ** $p \leq .01$. *** $p \leq .001$.

severity of disabilities, the lower the level of self-reported independence. Severity of disability was not correlated with sexual satisfaction.

Sexual satisfaction

The same analysis was used to analyze the relationships between sexual satisfaction (via NSSS Subscale A) and the different measures of independence that were self-reported. Sexual satisfaction was significantly positively correlated with level of independence of daily activities, $r(416) = .11, p \leq .05$; level of independence in social activities, $r(415) = .12, p \leq .05$; level of independence of interpersonal relationships, $r(415) = .14, p \leq .01$; and level of independence in sexual relationships, $r(416) = .18, p \leq .001$. This indicates that the higher the level of self-reported independence, there greater the sexual satisfaction.

Defining sexual activity

Using chi-square tests of independence, this study examined whether participants with different types of disabilities considered different types of activities to be “sexually active.” Table 3 illustrates these results.

Discussion

Given how narrow and unclear the definitions of sex and sexual activity can be, as discussed earlier in this article, the participants in this study had a very inclusive view of what counted as sexual activity, as masturbation (both solo and with partner), fondling, rubbing/frottage/scissoring, fingering/manual

stimulation/hand jobs, oral sex, vaginal penetration, anal penetration, other uses of sex toys, spanking/flogging/whipping, and power exchange/domination/submission all were considered to be sexual activity by more than half of the sample. Although it is not evident whether this expanded look at sexuality and sexual activity is unique to PWD, it does raise the question of how society is defining sex in everything from sex education to client intake forms, when people clearly have different thoughts about what qualifies as being sexual, as evidenced by the varied responses of participants in this study. Additionally, there was no singular activity (not even vaginal penetration) on which all participants had agreement as being defined as sexual activity. This indicates that conversations about sex and being sexually active need to be more diverse in definitions and inclusive of a variety of activities to be relevant and responsive to all individuals. It cannot be assumed that there are any activities that are considered to be sex by everyone; each person has his or her own definition. To more deeply explore how individuals in today's society define sexual activity, it would be interesting to compare how participants in this study defined activities as sexual or not with able-bodied individuals, as well as those with cognitive or socioemotional disabilities or impairments.

Disabilities are often lumped together as one catch-all construct, placing physical, cognitive, and socioemotional impairments, diagnoses, illnesses, and disabilities all into one larger umbrella category. Even the U.S. Census does not report on the specific types, severity, visibility or invisibility, or other more nuanced pieces of those living in the United States who have disabilities (U.S. Census Bureau, 2012). However, the data from this study reveal that there might be more differences between the experiences of different types of disabilities than previously thought. Although all of the participants in this study identified as having physical disabilities, there were still significant differences between those who had visible disabilities, those with invisible disabilities, and those who had both visible and invisible disabilities. Even from the perspective of descriptive statistics describing the sample, there were differences between types of disability in the areas of sexual orientation, race, gender identity, relationship status, and age, even though there were no differences in education level or severity of disability.

The analysis between types of disabilities showed that there is a difference between people with visible disabilities and those with invisible disabilities regarding the NSSS score of sexual satisfaction, with people with invisible disabilities having lower levels of sexual satisfaction than those who have visible disabilities. Also of note was that when examining how participants define sexual activity, there was a difference in whether people defined certain activities as sexual between types of disabilities. All of the significant differences in defining activities as sexual or not showed that people with invisible disabilities and people with both visible and invisible disabilities were more likely to

define these activities as sexual than those with visible disabilities. Of the 19 potential activities on the survey, 10 had significant differences between types of disability. Those activities that had a significant difference between types of disability were masturbation (solo), masturbation (with a partner), rubbing/frottage/scissoring, fingering/manual stimulation/hand jobs, vaginal penetration, anal penetration, other use of sex toy with partner, reading erotica (with partner), watching porn/adult videos alone and watching porn/adult videos (with partner). It is interesting that people with invisible disabilities had a wider range of what they defined to be sexual activity, yet had a significantly lower level of sexual satisfaction.

The correlation shown between sexual satisfaction and all four types of levels of independence (ADL, social activities, interpersonal relationships, and sexual relationships) indicates that it is not severity of disability that is negatively affecting the sexual satisfaction of PWD; rather, the more independent an individual feels he or she is across these contexts, the higher the correlation with an increased level of sexual satisfaction. This is an exciting finding, because although medical professionals and social service workers cannot do anything to change the severity of someone's disability, there is the potential to support an individual in increasing his or her level of independence. To offer PWD strong support concerning sexuality, helping professionals such as caregivers, case workers, counselors, and therapists can provide services and resources that allow their clients to be more self-reliant and to feel more independent in everything from getting dressed and taking a bath to engaging with other people and forming a variety of relationships.

Given the variety of different individuals that engage with PWD on a regular basis, such as medical professionals, mental health professionals, social service professionals, caregivers and aides, educators, and family members, it is clear there needs to be a bigger conversation on what sexuality means for PWD. How sex is defined needs to be reexamined to provide inclusive, diverse, and representative education and support to PWD, given their diverse definition of sexual activity. More effort needs to be placed on supporting individuals with disabilities in increasing their independence (in whatever way that might be identified by each individual), as it has been shown that higher levels of independence lead to increased sexual satisfaction. Additionally, more research and programming is needed on different types of disabilities, particularly on visible versus invisible (or having both visible and invisible disabilities) to best meet the differing needs of these communities, particularly in regard to sexuality.

Implications for social work education

Integrating the discussion of sexuality and disability within social work foundation courses—practice, policy, and research—is an ideal first step to

broadening the professional competency of our social workers in this area. Many social work programs' curricula might not cover sexuality or disability in detail, and when they do touch on these topics, might not offer their students the knowledge and space to have conversations and practice components at the intersection of these two arenas. Moving toward education that includes conversations regarding knowledge, attitudes, and beliefs regarding sexuality and disability would allow students the opportunity to ask questions, grapple with values and ethics surrounding society's views, and rehearse how they will engage with clients who have disabilities in their future practice.

Additionally, social work courses that discuss social justice should expand their understanding of sexuality as a human right. This includes moving beyond reproductive rights, and engaging areas of consent, marriage equity, gender identities and expressions, access to culturally grounded sexuality education, and even the access of PWD to being able to be sexual with partners. One way to offer more inclusive education in this area could be through encouraging cross-disciplinary electives with departments such as Disability Studies or Sexuality Studies, resulting in strengthened student competency in working within this community. Another way might be to collaborate with community organizations, or social workers who identify as having disabilities, to foster opportunities and partnerships for these important learning and practice opportunities to occur, both in the classroom and in the field.

Implications for social work practice

This study has implications for social work practice, starting with recognizing that the sexuality of PWD is an important and valid topic for social work attention. Acknowledgment is a vital first step in validating these communities. People with physical disabilities are sexual and their sexual health deserves respect. Our social work values and hallmarks of our profession such as strengths perspective and self-determination call our profession to support a sex-positive, pleasure-focused life for people with physical disabilities.

Social workers have the opportunity to influence agency policy about sexuality and how social service professionals support a holistic view of client sexuality. Ensuring that staff are able to offer culturally grounded practice through training is critical to implementation and can be directed by policy. Collaborative multidisciplinary work is another area where social workers can wield influence, making sure that the various support care teams in medical, rehabilitation, schools, skilled nursing facilities, and residential facilities are addressing a client's sexuality as part of the whole support structure. Social workers can model this starting with their own biopsychosocial forms, ensuring that sexuality questions are a part of the intake and exit planning sessions, and by normalizing conversations around sexual health and sexual activities.

Limitations

There are some limitations that should be considered when examining the findings of this study. One is the cross-sectional data, which were measured at one point in time, preventing researchers from interpreting trends over time, or the effects that changes such as an intervention might have had over time. Another issue is related to the type of measurement (a survey) accurately capturing the nuances of a multifaceted experience such as sexuality. Because experiences of sexuality are so individual and nuanced, this might have been difficult to capture in multichoice survey questions. The survey's language might not have been accessible to or understood by certain individuals participating; not everyone might have known the same definitions of each of the sexual activities, even if they had heard of them at all. Additionally, with any research that includes questions regarding people's identities, much of the language around gender, disability, and other demographics could have had multiple definitions that varied depending on who was engaging with and taking the survey. Some examples are terms like *disability*, whereas others might identify their experiences as impairments or illness, or not a disability at all. Due to this limitation, some participants might have opted to not answer some of the questions if they felt that they did not understand them, or they might have interpreted the questions in a unique way as compared to how the survey creator had intended, or how the author interpreted the data.

A second limitation is the fact that the Internet was the only vehicle of data collection. This could have resulted in excluding some members of the disability community, specifically those who might have limited Internet access, such as older individuals, low-income individuals, homeless individuals, and those with disabilities who are living in rural areas. Although the survey itself was checked to be compatible with multiple screen readers, it also might have been unavailable to those with visual impairments who did not have screen readers, or used software that was not compatible with the survey itself.

Conclusion

PWD have rich and varied experiences regarding their sexuality. In this larger picture are smaller pieces, such as how they define sexual activity, their levels of independence around ADL, social activities, interpersonal relationships, sexual relationships, and their level of sexual satisfaction. Not only do these play a part in the overall sexuality of PWD, but the type of disability someone has, and how it is perceived by others (visible, invisible, or both visible and invisible) could affect their experiences about defining sex, and their resulting sexual satisfaction. More research is needed to better understand these nuances. Additionally, those who work with PWD should adjust their policies and materials to provide more diverse definitions of sex and sexual activity to

meet the needs of this community. Those who work with PWD can also further support sexuality and sexual exploration of these individuals by working toward building independence in multiple contexts to increase their level of sexual satisfaction. Only with a better understanding of the sexuality of PWD can society finally view PWD as being just as sexual (or not sexual) as the rest of the population, allowing them access to culturally responsive education, counseling or therapy, and other resources that allow them to have their needs meet.

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