Title: Disability & sexuality: The challenges that are faced when disability and sexuality interact.

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# Introduction

America is obsessed with sex,[[1]](#footnote-1) and has been for a long time.[[2]](#footnote-2) However, the realization that people with disabilities have sexual desires is a relatively new idea.[[3]](#footnote-3) Before the 1970s, there was little to no research in this area of sexuality and disability,[[4]](#footnote-4) even within the disability studies literature.[[5]](#footnote-5) To start, it is worth noting what we mean by sexuality. The Sexuality Information and Education Council of the United States (SIECUS) defines sexuality “as multifaceted, having biological, social, psychological, spiritual, ethical, and cultural dimensions”.[[6]](#footnote-6) As we will see, this paper adopts the social model of disability. In terms of the quantity of persons with disabilities, over 56 million of US people (almost 20%) have a disability according to the most recent data in 2010.[[7]](#footnote-7) In terms of the amount of people engaging in sex in the US, among adults aged 25–44, about 98% of women and 97% of men had vaginal intercourse, and with 89% of women and 90% of men ever had oral sex with an opposite-sex partner.[[8]](#footnote-8)

Despite the numbers of persons with disabilities, the barriers facing sexual expression by this group are so extensive that Siebers argues that those with disabilities are a sexual minority. This category of persons are denied access to sexual experiences and control of their own bodies.[[9]](#footnote-9) Historically the topic of sex and disability “has been stigmatized as taboo.”[[10]](#footnote-10)

# Persons with disabilities are sexual beings

People are surprised that people with disabilities, particularly those that are institutionalized, are sexual beings.[[11]](#footnote-11) Emens explains that desexualization is the norm for those with disabilities.[[12]](#footnote-12) She goes on to explain that this involves an exclusion from the sexual realm.[[13]](#footnote-13) Shakespeare explains that due to the strong nature of the disability identity, it has “the power to de-sex people, so that people are viewed as disabled, not as men or women, straight or gay.”[[14]](#footnote-14) Mollow and Mcruer point out that “able-bodiedness is the foundation of sexiness” and that rarely persons with disabilities are regarded as desiring “subjects or objects of desire”.[[15]](#footnote-15) However, as Petersen has stated, contrary to stereotypes, persons with disabilities have active sexual lives.[[16]](#footnote-16) Unfortunately such stereotypes and other myths, that are seen as the most debilitating deep-seated in societal attitudes and cultures,[[17]](#footnote-17) are often internalized by persons with disabilities particularly when articulated by authority figures such as parents, teachers or carers.[[18]](#footnote-18) Such myths, according to Tom Shakespeare, are “ludicrous” and represent “the long‐standing prejudice that impairments are incompatible with sexual desire and sexual activity.”[[19]](#footnote-19)

According to Masters and Johnson’s influential model of sexual response, normal sexual behavior involves four stages: 1. Excitement; 2. Plateau; 3. Orgasm and 4. Resolution.[[20]](#footnote-20) If one’s sexual experience doesn’t fit into these discrete categories, one is deemed to be sexually dysfunctional. We can see here why persons with disabilities are viewed as being sexually dysfunctional, given widespread opinions that persons with disabilities do not have the capacity to have pleasure during sexual acts, never mind having an orgasm.[[21]](#footnote-21) Despite not fitting into these distinct 4 stages, persons with disabilities nonetheless view themselves as being sexually active.[[22]](#footnote-22) Persons with disabilities can be found at any stage across the sexuality spectrum, with just as many proportionately being homosexual as the general population.[[23]](#footnote-23)

# Barriers to sexuality

That said, while some have active sexual lives and all are sexual beings, they do face structural and cultural barriers to sexual and romantic opportunities.[[24]](#footnote-24) Evidence of this exists in statistics on marriage,[[25]](#footnote-25) where marriage acts as a proxy for intimate relations. There is a gap of almost 10% in terms of marriage rates when compared with persons without disabilities, and the gap is even wider when the disability is severe.[[26]](#footnote-26) Other topics, such as the presence of disability on and disabled users of dating sites, are also indicative of their sexual lives. According to Emens, disability is absent from all mainstream dating sites, with only one exception.[[27]](#footnote-27) Elsewhere, outside of mainstream dating sites, there is Lovebyrd which is exclusively for persons with disabilities.[[28]](#footnote-28)

## Sites of dating:

Furthermore, in traditional dating scenarios, we meet people at work or school where we develop relationships that could transpire to be of a sexual nature.[[29]](#footnote-29) Employment and education not only provide money that allows access to the dating market,[[30]](#footnote-30) but they also provide “cultural capital” and a network of friends from which romantic relationships may spur.[[31]](#footnote-31) Unfortunately such opportunities are denied to persons who have disabilities, as they may attend institutional specialized schooling and are often unemployed as an adult. Between 20% and 33% of persons with disabilities are employed in the US.[[32]](#footnote-32)

## Socioeconomic reasons:

Furthermore, the poor socio-economic background of many persons with disabilities presents further problems for dating and forming intimate relations.[[33]](#footnote-33) As Tom Shakepeare has said, “(b)eing sexual costs money”.[[34]](#footnote-34) This is important to note when we consider that 30% of people with mental disabilities live in poverty, while 24% of people with physical disabilities and 20% of those with sensory disability also live in poverty.[[35]](#footnote-35) Institutionalization, and the isolation that comes with it, may also block access to sexual partners.[[36]](#footnote-36)

## Physical accessibility:

Physical accessibility continues to provide a barrier to sexual relations,[[37]](#footnote-37) particularly the inaccessibility of dating sites, such as pubs and clubs. Shakespeare et al. point out that persons with physically apparent disabilities can be rejected from such sites on the basis that their disability is ‘unsightly’ and would negatively affect the aesthetic atmosphere and image of the club or pub.[[38]](#footnote-38)

## Personal characteristics:

More personal characteristics associated with those with disabilities also act as barriers, such as low self-esteem.[[39]](#footnote-39) Self-confidence and self-esteem are important for developing an active sex-life.[[40]](#footnote-40) Shuttleworth found that men with disabilities often have poor body images.[[41]](#footnote-41) Such self-perceptions are not surprising given the cultural norms of physical perfection,[[42]](#footnote-42) as perpetuated by the media,[[43]](#footnote-43) which confirm disabled people’s assumptions of inferiority.[[44]](#footnote-44) Many persons with disabilities perceive their disability as something to hide, particular during sexual interactions.[[45]](#footnote-45) Having said that, as Solomon’s book demonstrates, for certain types of disability, such as deafness, blindness and dwarfism, there exists a dominant sub-culture that persons with such disabilities can belong to and can seek out partners within that sub-culture.[[46]](#footnote-46)

## Carers:

Reliability on third parties for day to day care such as getting to bed and getting changed can provide further challenges for intimacy. Dependency on personal assistants may continue into the more private realm of sexuality. One participant in the book by Shakespeare et al., argues that on the basis that the non-disabled are able to masturbate, persons with disabilities who cannot do so on their own, should be assisted in order to do the so.[[47]](#footnote-47) Although personal sexual assistance is still a controversial issue, many individuals with disabilities require physical help to get into positions that facilitate sexual activity.[[48]](#footnote-48)

Finally, it should be noted that “(t)he more people with disabilities achieve their other civil and social rights, the more they will have the confidence, self‐esteem and desirability that make relationships possible.”[[49]](#footnote-49)

# Types of sexuality associated with persons who have disabilities

Taking a step back, while there has been a wide liberalization around sexuality in general,[[50]](#footnote-50) the same cannot be said for the disability community. This is partly due to their inability to have a political voice to demand change.[[51]](#footnote-51) As Foley explains “while the dominant values have changed, sexual expression remains shot through with normative restrictions depending on what social category one falls into. By extension social groups which lack power, also lack the ability to define and regulate their own sexuality.”[[52]](#footnote-52) As a result, the discourse around disability and sex is one that is infantilized[[53]](#footnote-53) and characterized by protectionism.[[54]](#footnote-54)

## Parental regulations:

Such regulation of the sexual lives of persons with disabilities as akin to children is often enforced by parents.[[55]](#footnote-55) Parents of those with disabilities are often reluctant to acknowledge their children’s potential to be sexual beings.[[56]](#footnote-56) Their position of power over those with disabilities, combined with a misunderstanding of the sexual nature of their children, culminates in such parents presenting barriers to sexuality for their disabled children.[[57]](#footnote-57)

Having said all of the above, one study reports that persons with disabilities have sex at younger ages.[[58]](#footnote-58) Tom Shakespeare argues that this is partly due to abuse, but also due to such individuals wanting to feel accepted among their peers.[[59]](#footnote-59) As stated above, certain disabilities bring with it a distinct sub-culture, such as the Deaf community, where access to sexuality is not as large of an issue.[[60]](#footnote-60)

## Judicial concerns:

Many wish that this ‘uncomfortable’ policy issue would just disappear,[[61]](#footnote-61) including the courts. It should be noted that judges are uncomfortable adjudicating cases of this nature that involve the crossover of sexuality and disability.[[62]](#footnote-62) Often these cases pit protective parents against their children with disabilities,[[63]](#footnote-63) with many cases involving the parents seeking to sterilize their sexually active children.[[64]](#footnote-64) *Buck v Bell*[[65]](#footnote-65) is an infamous case of court-sanctioned forced sterilization, where Justice Holmes stated that “(t)hree generations of imbeciles are enough.”[[66]](#footnote-66)It is also worth nothing that forced sterilization has been found to constitute torture, according to the immigration judge in *Bi Zhu Lin v. Ashcroft*.[[67]](#footnote-67)

## Societal views:

Sexual acts between those with disabilities is perceived more negatively than persons without disabilities.[[68]](#footnote-68) Parents of non-disabled children often disapprove of relationships with those who have disabilities.[[69]](#footnote-69) These disapprovals from society and families,[[70]](#footnote-70) in addition to other barriers to sexuality, culminate into a form of “erotic segregation”.[[71]](#footnote-71) According to Willock, “(s)ex and disability provokes moral panic” which in turn delegitimizes and stigmatizes the sexual agency of people with disabilities.[[72]](#footnote-72) Many persons with disabilities are left out of sexual discussions in the home.[[73]](#footnote-73) Families expect persons with disabilities to have “no sexual feelings, or show any interest as sex as adolescents.”[[74]](#footnote-74) In a British study called ‘Sexual Health and Equality’, 37% of respondents stated that their parents and teachers did not expect them to form relationships with partners or have children in the future.[[75]](#footnote-75) There is a dichotomy upheld by families, that persons with disabilities are characterized by tragedy and passivity, while adolescence is ordinarily associated with sex and risk.[[76]](#footnote-76)

In fact, until the deinstitutionalization movement took force in the 1960s, sterilization was a prerequisite to discharge from the institutions,[[77]](#footnote-77) for example, in the case *In Re Cavitt*.[[78]](#footnote-78)

Sex between two people with disabilities is a highly charged emotional issue.[[79]](#footnote-79) Stigma attaches to the intersection of disability and sex.[[80]](#footnote-80) Misconceptions and myths surround the discussion, with some believing that those with disabilities have no biological sex drive[[81]](#footnote-81) and others thinking that having sex with a person with a mental disability will have contagious consequences,[[82]](#footnote-82) or as Emens says, “potentially tainting the human race”.[[83]](#footnote-83) This is particularly evident in contexts of persons with disabilities having families, where our disability-phobic society generates irrational fears around the bearing of children by persons with disabilities.[[84]](#footnote-84)

## Sexual oppression:

Few academics are interested in the topic, it is only since the early 1990s that academic interest has begun to blossom.[[85]](#footnote-85) Not only is there a lack of policy and legal literature, there is an absence of hospital guidelines on the subject.[[86]](#footnote-86) Furthermore, while the disability movement and disability studies commentators focused on the public problems faced by those with disabilities, often concerns in the private regime were ignored, which also occurred and contributed to a form of sexual oppression.[[87]](#footnote-87) We should examine sexuality from a social model of disability, in that often it is external barriers that violate the right to sexual contact, such as inaccessible spaces, and legal prohibitions on such conduct, rather than the disabilities themselves.[[88]](#footnote-88) “Quite simply, (the social model of disability) challenges the traditional view of disability as a medical tragedy, and replaces it with a view of disability as a social oppression. In sociological terms, this is about arguing that disability is socially constructed not biologically determined.”[[89]](#footnote-89) As bell hooks has stated, “(o)ppressed people resist by identifying themselves as subjects, by defining their reality, shaping their new identity, naming their history, telling their story”.[[90]](#footnote-90)

Finally, we should ask, as Tom Shakepeare does, whether the disability community want more sex in the first place. He explains that “(m)ost people are not looking for sex itself, they are searching out intimacy, warmth, validation, connection. That is, relationships rather than sex are what counts.”[[91]](#footnote-91) Persons with disabilities have the same demands for love and affection, including the expression of such notions.[[92]](#footnote-92)

## Asexual or sexual deviants

Some perceive persons with disabilities as sexual deviants[[93]](#footnote-93) who are sexually uncontrollable[[94]](#footnote-94) characterized as having a hyper-sexuality and being sexual predators,[[95]](#footnote-95) while others see them as asexual.[[96]](#footnote-96) Some fail to see their human needs for affection and ways of expressing that affection,[[97]](#footnote-97) i.e. they are perceived in terms of “tragic deficiency or freakish excess.”[[98]](#footnote-98) As Shakespeare et al. point out, sometimes they are “fetishized as objects”.[[99]](#footnote-99) However, where disabled people are seen as sexual, this is in terms of deviant sexuality, or the perception of persons with disabilities as perverts, for example with inappropriate sexual display or masturbation.[[100]](#footnote-100) No other group experiences the same level of sexual and reproductive restrictions,[[101]](#footnote-101) whereby these restrictions are steeped in a history of institutionalization and sterilization.[[102]](#footnote-102) A number of myths continue to surround the issue of sex and disability, including asexuality, and inabilities to conceive, or to have orgasms.[[103]](#footnote-103) Similarly, those with disabilities who are single are presumed to have chosen this option rather than pursuing the option of marriage or cohabitation.[[104]](#footnote-104) When marriage is present, it is presumed to have been desired by the non-disabled entity for perverse incentives.[[105]](#footnote-105)

## Prostitution

As a result of such restrictions and prohibitions, sometimes the only avenue for sexual conduct is to pay for it through prostitution.[[106]](#footnote-106) This had led Fritsch et al. to call for the decriminalization for such clientele.[[107]](#footnote-107) Interestingly, in a case from Denmark, the court ordered governmental officials to pay for expenses associated with using a call girl.[[108]](#footnote-108)

## Tensions

There is a “tension between autonomy and a right to sexual expression on the one hand, and concerns about coercion and abuse on the other.”[[109]](#footnote-109) Another conflict that needs to be balanced is the competing concerns for the legal rights to control one’s own sexuality and the ‘moral right’ of parents to protect their adult children from exercising such rights.[[110]](#footnote-110) Certain disabilities, such as Down Syndrome, exhibit behaviors that are likely to acquiesce in the presence of authority figures, such as parents or carers.[[111]](#footnote-111) This not only explains how such individuals fail to exercise and voice their own rights in relation to sex,[[112]](#footnote-112) but also explains how they are particularly susceptible to sexual abuse.[[113]](#footnote-113) Other reasons for this enhanced risk of sexual abuse and exploitation include the dependency of victims on others for care, social isolation, a lack of sex education, oppression and the perpetrator’s perception that they will not be caught by the authorities.[[114]](#footnote-114) In fact, sexual abuse of those with disabilities is one of the most under reported crimes.[[115]](#footnote-115) It has been reported that between 80% and 90% of persons with disabilities will experience some type of abuse in their lifetime.[[116]](#footnote-116)

It is important to note that in terms of persons with Down Syndrome, they have largely been successfully integrated into society, but most still live with their parents.[[117]](#footnote-117) Living with one’s parents creates barriers to sexual autonomy, for instance the issue of finding somewhere private to engage in sexual behavior.[[118]](#footnote-118) This is a broader problem for most people with disabilities, not just those living with their parents or those who are institutionalized. There is a lack of private safe places to engage in sexual activity. As Hingsburger and Tough have stated, one cannot express sexuality without privacy.[[119]](#footnote-119) The access to privacy is even more important given the fact that public displays of affection on the part of a person with disability is often met with societal disapproval,[[120]](#footnote-120) despite such behavior as being normal for heterosexual non-disabled persons. As Brown points out, the disability movement and individuals with disabilities must challenge what is normal when it comes to sex.[[121]](#footnote-121)

# Institutionalized persons

“Institutionalized persons do not lose their sexuality when they lose their liberty.”[[122]](#footnote-122) While some believe that sexuality should form part of the patient’s treatment plan[[123]](#footnote-123) due to its therapeutic value,[[124]](#footnote-124) others argue that it should be prohibited entirely.[[125]](#footnote-125) These calls for prohibition are based on the discriminatory notion of over-protectionism,[[126]](#footnote-126) with Perlin and Lynch stating that “(t)he denial of the right to sexual autonomy often is articulated as stemming from the desire to protect vulnerable people”.[[127]](#footnote-127) The calls for prohibition on sex are also due to potential liability for institutions should illegal sexual activity occur on their premises by patients under the institution’s care.[[128]](#footnote-128) Often staff of such institutions are against sexual acts between patients,[[129]](#footnote-129) and generally professional services fail to take the sexual issues of persons with disabilities seriously.[[130]](#footnote-130) As Stevens points out, all activities are monitored and controlled in such institutions so as to deny any opportunities for sexual activities.[[131]](#footnote-131) This cumulatively leads to “highly restrictive sexual environments.”[[132]](#footnote-132) “Now, shifts towards community care plus more enlightened attitudes may open up more possibilities for relationships”.[[133]](#footnote-133) Further sexual liberalization may occur on foot of case law, such as the case of *Foy v Greenblott*[[134]](#footnote-134) a 1983 case, which states that institutionalized patients have a right to engage in voluntary sexual relations. The plaintiff was denied her right to reproductive choice by the institution failing to provide the plaintiff with contraceptive devices.[[135]](#footnote-135)

Similar to institutionalization, special schooling provides another restrictive segregated environment for learning about sex and finding sexual partners.[[136]](#footnote-136) Being removed from families, friends and communities at young ages[[137]](#footnote-137) leaves youths with disabilities isolated and being denied bonds that are essential for sexual development.[[138]](#footnote-138)

# Incapacity/Competence to Have Sexual Relations

“Sexual incapacity doctrines are perhaps the most important form of sexual regulation, as they control access to sex by designating who is legally capable of sexual consent.”[[139]](#footnote-139) They also influence social norms about sexuality.[[140]](#footnote-140) As Perlin and Lynch point out, we must start with the assumption that every human, disability or not, has the capacity to consent to sexual relations.[[141]](#footnote-141) The right to sexual expression should not be denied on the basis of disability alone.[[142]](#footnote-142) We need to distinguish between laws that protect people who have temporary cognitive impairments due to intoxication and laws that prohibit sex on the basis of persistent cognitive disabilities, such as Down Syndrome or Alzheimer’s Disease.[[143]](#footnote-143) Incapacity tests should assess the mental capacity to understand the nature and consequences of sexual decisions.[[144]](#footnote-144)

Capacity “refers to an individual's actual ability to understand, appreciate and form a relatively rational intention with regard to some act”.[[145]](#footnote-145) Consent concerns an individual’s ability to understand: the sexual nature of an act; that participation must be voluntary; the consequences of consensually engaging in the sexual act; and the ability to communicate all of this.[[146]](#footnote-146)

Courts are divided on what competency is required in this context. Some courts require an understanding of the sexual nature of the decision, others also require an appreciation of the moral elements of such decisions, and others still, require an understanding of the possible consequences of such decisions.

Both criminal and civil liability can ensue.[[147]](#footnote-147) However, it should be pointed out that consent acts as an affirmative defense to most criminal sex offenses.[[148]](#footnote-148) There is a “presumption in American law that an individual has the prerequisite capacity to engage in a sexual relationship once he/she reaches the age of consent.”[[149]](#footnote-149) Having said that, what if the individual has difficulties in providing consent due to their disability?[[150]](#footnote-150) People should have the opportunity to make sexual decisions with support from caregiving networks.[[151]](#footnote-151) They should not be presumed to lack capacity to give consent. *People v Dean*[[152]](#footnote-152) reversed a conviction of statutory rape, where the defendant had sexual intercourse with a woman who had a developmental disability. The court stated that if the conviction was upheld, essentially anyone who had sex with the victim would face statutory rape charges, and so we can see that the sexual freedom and autonomy of the individual with the disability would have been undermined.

Some states have opted for legislation pertaining to rape of those with disabilities that hinges on the ability of the victim with disability to be “physically helpless”. *State v Fourtin* presents a stark example of how such laws fail to protect those with disabilities. Here, the defendant was found not guilty of rape on the basis that the victim L.K. was not physically helpless and was so able to consent.[[153]](#footnote-153) Under such laws, physically resisting rape by fighting back acts as evidence that the victim is not “physically helpless”.

In terms of gaining sexual autonomy and the right to have sex, the disability movement has become synonymous with a language of rights and citizenship.[[154]](#footnote-154) As Foley explains, “to possess a legal right is to possess a protected choice in the form of a legal entitlement to do, or get something, with a corresponding duty on a third party to not violate that right.”[[155]](#footnote-155) Formal rights give persons with disabilities the legal authority to make decisions for themselves instead of substitute decision making or decision making by proxy.[[156]](#footnote-156)

# Sterilization

Up until quite recently there was some American states that had involuntary sterilization.[[157]](#footnote-157) Sterilization has its roots in the eugenics movement, where the purpose of sterilization was to eliminate the possibility of inheriting disabilities.[[158]](#footnote-158) “Eugenic sterilization of those with physical or mental deficiencies was viewed as a solution to improving the human race.”[[159]](#footnote-159)

# Parental rights

Often parental rights of those with disabilities are denied or terminated, particularly for those with intellectual or developmental disabilities.[[160]](#footnote-160) This denial of parental rights can manifest itself through the intervention by protective child services or during custody battles where a parent with a disability is often deemed to be unfit to be parent.[[161]](#footnote-161)

The right to bear a family and the right to marriage is found in most human rights treaties, including Article 10 of the International Covenant on Economic, Social and Cultural Rights, Article 16 of the Universal Declaration of Human Rights, Article 23 of the International Covenant on Civil and Political Rights, Article 8 of the European Convention on Human Rights, and Articles 12 and 23 of the Convention of the Rights of Persons with Disabilities (“the CRPD”).

Shakespeare argues that persons with disabilities should not be denied the right to parenthood, but instead should receive parenting support in order to exercise this right.[[162]](#footnote-162)

# Sex Education

Both adults and youths with disabilities report low levels of information on sexuality.[[163]](#footnote-163) For specific disabilities that face communication difficulties there fails to be accessible formats of sexual information, such as braille, tape or simple English formats.[[164]](#footnote-164) “It is not surprising that confusion, guilt and silence are the end result”.[[165]](#footnote-165) One way of counteracting this trend is through sex education,[[166]](#footnote-166) which Shakespeare et al. characterize as being vital for the development of persons with disabilities.[[167]](#footnote-167) Persons with disabilities often face barriers to accessing sex education as youths.[[168]](#footnote-168) One possible reason for this is the fact that some persons with disabilities attend ‘special education’ schools, specific to persons with disabilities, where sex education would not be seen as a priority given the myths surrounding sex and disability.[[169]](#footnote-169) Another reason may be that parents and teachers, in an expression of the commonly held over-protectionism surrounding persons with disabilities, are opposed to learning about sex as it may encourage sexual activity from a young age.[[170]](#footnote-170)

Sex education should be provided to all young people, regardless of disability or special education.[[171]](#footnote-171) Given the dangers of sex, such as unwanted pregnancies, sexual abuse, HIV/AIDS and other STDs, in addition to the “ignorance, misinformation, embarrassment and peer pressure” around sex and disability, it is essential that correct information regarding sex and safe-sex is provided.[[172]](#footnote-172)

Fishcel and O’Connell explain that disability specific sex education has been around for two decades now.[[173]](#footnote-173) However, the quality of such sex education is questionable. For example, a 2010 Canadian Council for Learning study reports that 100% of participants felt their sex education was inadequate.[[174]](#footnote-174) An Irish study has shown that sex education for those with disabilities improves not only knowledge of sex, sexuality and safety, but it also improves the capacity to make sexual decisions.[[175]](#footnote-175) It has been shown that persons with disabilities who do not receive such sex education are more likely to experience sexual exploitation and abuse.[[176]](#footnote-176) One study by McCabe et al., reports that those who do not have sex education report low levels of sexual knowledge and negative feelings towards sexuality, yet they also report high levels of sexual needs.[[177]](#footnote-177) There is a strong desire among such groups to know more about disability and sex.[[178]](#footnote-178)

Stevens points to the politicized nature of disability and sexuality, and how people with disabilities are sexually oppressed.[[179]](#footnote-179) However, Waxman points out that the disability movement has been reluctant to make sexuality a political issue.[[180]](#footnote-180) Finger explains that “(s)exuality is often the source of our deepest oppression”.[[181]](#footnote-181)

# Benefits of sex

According to Sy, many people believe that sex for those with disabilities would be physically and emotionally unhealthy.[[182]](#footnote-182) However, the opposite is actually the case. There is a key relationship between sexual well-being and psychological well-being.[[183]](#footnote-183) In fact, it has been reported that sexual intercourse leads to a longer life expectancy.[[184]](#footnote-184) Sex not only has emotional benefits such as fostering close personal relationships[[185]](#footnote-185) and providing pleasure,[[186]](#footnote-186) but actually has positive health benefits such as “analgesic effects, hypertension reduction, and increased relaxation”.[[187]](#footnote-187) It also provides mental health benefits,[[188]](#footnote-188) in addition to “greater physiological and psychological satisfaction.”[[189]](#footnote-189) Furthermore, “sexual expression via the medium of sexual relations is a fundamental aspect of human behaviour.”[[190]](#footnote-190) The ability to have sexual relations is at the heart of what it means to be human.[[191]](#footnote-191) That said, there are also certain healthcare risks that sexually active persons with disabilities face, such as the increased risk of getting HIV/AIDS.[[192]](#footnote-192) This is particularly concerning when we think of how people with disabilities also face difficulties accessing adequate healthcare.[[193]](#footnote-193)

# Healthcare

People with disabilities often face barriers to adequate healthcare, in particular reproductive healthcare. Following the medical model of disability, doctors often fail to treat other general health concerns of disabled patients and instead focus on issues related to their predominate disability.[[194]](#footnote-194) In terms of family planning, not only are the premises of such services inaccessible for those with physical disabilities, the attitudes of staff are often prohibitive.[[195]](#footnote-195)

# ADA

The Americans with Disabilities Act is relatively silent on sexuality. Disability and sexuality only meet expressly in the ADA in Sections 507-512 of Title V, where the statute states that the term disability shall not apply to an individual because of them identifying as a transvestite. As Malti-Douglas points out, “(o)ne might think that America was threatened by an imminent plague of transvestism.”[[196]](#footnote-196)

However, the Supreme Court when confronting what the ADA means for those with HIV/AIDS, delved into a discussion of sex and disability, albeit it subliminally. This occurred in the case of *Bragdon v. Abbott*,where the Court found that HIV was an impairment under the ADA, on the basis that “reproduction and the sexual dynamics surrounding it are central to the life process itself” and so satisfied the major life activity.[[197]](#footnote-197) In doing so, the Court announced that sexual intercourse, or rather, reproduction are a major life activity and “could not be regarded as any less important than working and learning”.[[198]](#footnote-198)

The ADA has largely been successfully if we examine it through certain lenses. For instance, from a physical disability perspective, public places have now largely become accessible.[[199]](#footnote-199) Similarly the fight against discrimination in schooling and employment has come a long way.[[200]](#footnote-200) However, when we consider the lack of cultural change around sex and disability, the ADA has largely failed. As Finger points out, it is easier to talk about and solve issues such as “discrimination in employment, education and housing” than to do the same with the disability community’s cultural exclusion from sexuality.[[201]](#footnote-201) The latter is treated as a lower concern for disability studies and for the disability movement.[[202]](#footnote-202) The disability movement itself was criticized by Finger for failing to advocate sufficiently for sexual rights.[[203]](#footnote-203)

# CRPD

The CRPD calls for the elimination of discrimination in respect of interpersonal relationships in Article 23 and also in respect of sexual and reproductive health services in Article 26.

The Committee on the Rights of Persons with Disabilities, set up via the CRPD, has the power to issue Concluding Observations on reports of member countries. Many of these Concluding Observations are illustrative of the duties member countries of the CRPD face in relation to disability, sexuality, family and marriage. Here the author of this paper looks at the years 2016 and 2012 as representative of all years of concluding comments. In 2012, Peru was urged to change domestic law that denied the right to marriage on the basis of certain disabilities.[[204]](#footnote-204) In the same year, Argentina was criticized for its domestic provisions, Article 309 of the Civil Code of Argentina, that denied marriage to those found to be “insane” or those who lacked capacity. The Committee not only demanded that such laws were to be amended, but placed positive duties on the Argentina government to provide support services to assist such individuals in exercising their right to marriage.[[205]](#footnote-205) A similar statement was made in respect of Hungary in 2012.[[206]](#footnote-206) In relation to Article 5 on equality and non-discrimination, Spain was criticized in 2012 for laws governing guardianship and custody of children that took disability into account.[[207]](#footnote-207) In relation to the Article 25 right of access to sexual and reproductive health, Paraguay was found to be at fault for discriminatory provision of sexual and reproductive health services for those with disabilities.[[208]](#footnote-208) Hungary and China were both tasked with protecting individuals with disabilities from forced sterilization.[[209]](#footnote-209) Almost all countries were at fault when it came to the access to and exercise of sexual and reproductive rights.[[210]](#footnote-210) Some states were criticized for the sexual abuse of and violence toward women with disabilities.[[211]](#footnote-211) Uganda was specifically targeted for its “sexual violence, abuse and exploitation” against women and also for societal myths around people with disabilities being asexual on the one hand, and also that having sex with someone with a disability would cure that person of HIV/AIDS. Furthermore, the Committee pointed to Uganda’s Divorce Act (1904) and the Hindu Marriage and Divorce Act 1961 as discriminating against those with disabilities and their right to marriage. Guatemala was also singled out by the Committee stating that it was “concerned that persons with disabilities, especially women and girls who have been sexually abused, deprived of their legal capacity and/or institutionalized, are subject to sterilization, abortion and other contraceptive treatments without their consent.”[[212]](#footnote-212) The United Arab Emirates was tasked with introducing a criminal statute that would criminalize sexual violence.[[213]](#footnote-213)

Not only does the above Concluding Observations illustrate the global nature of the issues associated with sex and disability, it also shows the challenges the US may face should they eventually ratify the CRPD.

# Solutions

Blanket prohibitions on sexual activity by persons with disabilities should be abolished, as called for by Emens.[[214]](#footnote-214) Otherwise, if left on the statute book, these restrictions contribute to the stigmatization of those with disabilities.[[215]](#footnote-215) Marriage penalties should also be lifted with certain state and federal provisions terminating disability benefits upon marriage.[[216]](#footnote-216) For instance, the Social Security Administration’s Supplemental Security Insurance includes the resources of a cohabitant or spouse when calculating the income of a person with disability.[[217]](#footnote-217) We should also look to more structural issues such as poverty, unemployment and discrimination which inhibit access to the dating market.[[218]](#footnote-218) Simple issues such as physical accessibility to pubs and nightclubs could go a long way in alleviating the barriers to starting intimate relationships.[[219]](#footnote-219) It appears that attempts of making the dating market accessible are falling short. For example, accessible transport systems often fail to offer space for a companion, which makes it difficult for persons with disabilities to go to private spaces such as their home or the home of their sexual partner.[[220]](#footnote-220)

# Conclusion

This paper has unearthed the silent oppressive nature of the cross-over of sex and disability. The discourse of disability and sex is characterized by oppression and myths. Persons with disabilities are either perceived as hyper-active or asexual when it comes to their sex lives. It is only a recent revelation that persons with disabilities have the same sexual desires as those without disabilities. Unfortunately, those with disabilities face many social, familial, economic and structural barriers to their sexual freedom. Persons with disabilities in institutions face even greater barriers. Often these barriers stem from myths around sex and disability. One solution offered by this author is the promotion and increased utilization of sex education for persons with disabilities. Should the US government not step up and alleviate such barriers, they may face international criticism in the future upon ratification of the CRPD. Measures made to allow for sexual expression, marriage and family creation should be taken now, rather than as a result of such international pressure.

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211. Committee on the Rights of Persons with Disabilities, *supra* note 209 (Lithuania), para 18; Committee on the Rights of Persons with Disabilities, *supra* note 209 (Chile), para 51; Committee on the Rights of Persons with Disabilities, *supra* note 209 (Uganda), para 32; Committee on the Rights of Persons with Disabilities, *supra* note 209 (Serbia), para 23; Committee on the Rights of Persons with Disabilities, *supra* note 209 (Guatemala), para 49; Committee on the Rights of Persons with Disabilities, *supra* note 209 (Colombia), para 45; Committee on the Rights of Persons with Disabilities, *supra* note 209 (United Arab Emirates), para 45. [↑](#footnote-ref-211)
212. The Committee on the Rights of Persons with Disabilities, *supra* note 209 (Guatemala), para 49. [↑](#footnote-ref-212)
213. The Committee on the Rights of Persons with Disabilities, *supra* note 209 (United Arab Emirates), para 31 (a). [↑](#footnote-ref-213)
214. Emens, *supra* note 12, at 1390. [↑](#footnote-ref-214)
215. *Ibid*. [↑](#footnote-ref-215)
216. *Ibid*. [↑](#footnote-ref-216)
217. Stevens, *supra* note 106, at 62. [↑](#footnote-ref-217)
218. Emens, *supra* note 12, at 1391-1392. [↑](#footnote-ref-218)
219. *Ibid*., at 1392-1393. [↑](#footnote-ref-219)
220. J. Bahner, Legal *rights or simply wishes? The struggle for sexual recognition of people with physical disabilities using personal assistance in Sweden*, 30 Sexuality & Disability 3 (2012). [↑](#footnote-ref-220)