LEADING COMMENT

Sexuality, human rights and safety for people with disabilities: the challenge of intersecting identities

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The link between living with a disability and an individual’s risk of being disadvantaged or discriminated against is clear. However, the focus is often on issues of equity and access to employment and services and the physical health needs of individuals. When focusing broadly on rights, the gender and sexuality of people living with a disability can easily be rendered invisible, or subjugated to other seemingly “higher order” issues. Broader issues of the sexual health, sexual identity and sexual expression of people with a disability needs to also be brought into focus. Drawing on research from Australia and internationally, this paper provides a brief overview of the experience of sexual assault and sexual victimisation, homophobia and gender-based discrimination for people with a disability. Recognising and balancing these complex and sometimes apparently competing self-identities and needs is complex, yet is integral from a human rights perspective.

Keywords: sexuality; disability; human rights; diversity; identity

Introduction

It can be a complex challenge for health professionals and researchers working in the field of sexuality and relationships to recognise the diversities that are embodied in people’s lives – in particular, of recognising the intersection between sexuality and disability issues. However, the gender and sexuality of people living with a disability can easily be rendered invisible. It is important to “un-silence” the gendered, sexual nature of people living with disability. This involves highlighting the continuum of ability-disability of people across the diversity of sexual orientations, gender identities, gender roles and expressions of sexual behaviour. It also involves a move from thinking about “collision” of identity categories to “intersections” and “overlaps”.

A number of authors have highlighted some of the issues faced by people who have membership of multiple identity-based communities (e.g. Brownworth & Raffo, 1999; Clare, 1999; O’Toole, 2000). The challenge occurs at the intersections between gender, race, disability, sexual identity and sexual behaviour. As O’Toole argued:

Whenever we see overlapping intersections of difference from the norm, complexity, not simplicity, results . . . I would propose that the effort to present a simplistic, “people with disabilities are just a little different than you,” message has significant and
Some of the issues identified by those writing about the margins – as well as the intersections – of identity for people with disabilities include: challenging society’s heterosexist assumptions; “passing” as non-disabled and coming out twice – not just as “queer”, but as “disabled”; acknowledging and confronting layers of discrimination; accessing education/information that recognises diversity and difference; and creating space for positive, joyful sexuality. This does not just mean that disabled lesbians, for example, are “doubly oppressed” – but perhaps that they also are freer to be non-traditional and challenge conventional norms (O’Toole, 2000).

The scope of the issue

Around 10% of the world’s population, or 650 million people, live with a disability (United Nations, n.d.). They are the world’s largest minority. However, prevalence data are influenced by the particular definition or inclusion criteria. For the purposes of Australia’s national statistical data collection, disability is defined as any limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities. Examples range from hearing loss that requires the use of a hearing aid, to difficulty dressing due to arthritis, to advanced dementia requiring constant help and supervision (Australian Bureau of Statistics [ABS], 2004).

Taking Australia as an example, approximately one in five Australians reports that they have a disability. The overall disability rates for males (19.8%) and females (20.1%) were almost identical. However, the gender balance is not reflected internationally, particularly for developing countries, where the United Nations (UN) acknowledges that women disproportionately bear the burden of disease in terms of disability and its impact (UN, n.d.). In Australia, just over half (51%) of people aged 60 years and over had a disability (ABS, 2004).

Caring for a family member with a disability

The intersection of disabilities and sexuality exists not only in terms of the gender of the person living with a disability (where – as I argue later – women with disabilities are disproportionately represented in violence and abuse statistics), but also in terms of the gendered nature of how care needs are met. Out of a population of approximately 20 million in 2003, there were 2.6 million people in Australia providing assistance to someone who needed help because of disability or age. Of these carers, 474,600 (or 1 in 5) were the “primary” carer, providing the majority of informal help to a person with a disability. Just over half (54%) of all carers were women; however, women were more likely to be primary carers (71% were women) (ABS, 2004). The gendered nature of the primary care role is an important example of the intersection of identities and the challenges this can present.

A recent study of 1002 carers in Australia showed that caring for a family member with a disability had a significant impact on primary carers (who are mostly women) in areas like employment, but also social contact (Edwards, Higgins, Gray, Zmijewski, & Kingston, 2008). Compared to non-carers from the general population, carers experienced (1) higher rates of mental/physical health problems;
lower workforce participation; and (3) higher levels of financial hardship. Carers also experienced reduced social networks; relationship conflict and breakdown; wider family conflict (particularly when caring for someone with a psychiatric disability); and one in five had no assistance from others in their care role (Edwards et al., 2008).

Both relationships and social networks are intricately linked to the human rights and sexual wellbeing of people. Therefore, these data exemplify how disability can have indirect effects on relationship/sexuality issues for carers, as well as on the individuals with the disability.

Human Rights, diversity and feminist frameworks

A number of models have been used to theorise about and explain the circumstances and lived experiences of people with disabilities. These include: medical (focusing on the health or physical restrictions and their consequences); social justice (focusing on the equity needs of people living with disabilities); citizenship (addressing participation and inclusion in civic and community life); and human rights models (focusing on the right to equality and freedom from discrimination) (Mackelprang & Salsgiver, 1999; O’Hare, 1999; Oliver, 1990). However, there are diverse views and criticisms concerning each model. Some authors have gone as far as to problematise any models that rely on a dichotomy between “able-bodied people” and “disabled people” (Shakespeare & Watson, 2002).

Rights-based, participatory and strengths-based models represent a significant paradigm-shift from earlier medicalised, problem-based models for understanding the lived experience of people with a disability. However, a broad focus on human rights for people living with a disability can still render their gender and sexuality invisible or subjugated to other seemingly higher-order issues (Kelly, 2005). The link between living with a disability and an individual’s risk of experiencing inequality or discrimination is clear. This is particularly the case in developing countries, where, from a public health perspective, there is a greater “burden of disease” from disability (UN, n.d.). However, the focus is often on issues of equity and access to employment and services and the physical health needs of individuals. Moving away from a medical model of disability to a human rights perspective calls into focus the broader issues of a person’s sexual health, sexual identity and sexual expression.

Over the past three decades, there have been two milestone achievements at the international level in terms of understanding the needs and promoting the human rights of people living with a disability: (1) The International Year of Disabled Persons in 1981; and (2) The UN Convention on the Rights of Persons with Disabilities, which came into force on May 3, 2008. According to the UN, the major lesson of the International Year of Disabled Persons was that social attitudes are the major barrier to the realisation of the goal of full participation and equality in society by persons with disabilities (UN, n.d.).

The UN Convention on the Rights of Persons with Disabilities recognises the inherent dignity and worth and the equal and inalienable rights of all members of the human family – and it acknowledges that discrimination based on disability is a violation of this right. The preamble to the UN Convention notes some important issues. Disability is an evolving concept. While there is enormous variation in how disability is defined, common elements refer to a condition that curtails to some degree a person’s ability to function (relative to a personal or group standard or
norm) – whether that incapacity is physical, intellectual or psychiatric, or whether it is congenital or results from an injury or illness.

The UN Convention also recognises the interaction between persons with impairments and the attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others. It is important for people with a disability to have autonomy, independence, freedom of choice and involvement in decision making that affects them (UN, 2008).

However, these international policy frameworks fail to explicitly mention sex and sexuality. Issues of gender and violence are recognised, but not broader issues of sexuality and sexual rights – in terms of diversity of sexual identity, positive sexual expression, sexual health, sexuality education and freedom from sexual violence. This suggests that even within a discourse on human rights, there is a risk that the gender and sexuality of people living with a disability can easily be rendered invisible or subjugated to other seemingly “higher order” issues (O’Hare, 1999).

A diversity framework provides an alternate, but complementary lens through which to view the sexual diversity and sexuality issues for people with a disability, their families and carers. Diversity frameworks have often focused on education (in terms of curriculum) or organisational issues (such as access and equity policies regarding employment and workplace practices). It moves beyond “difference” (where the minority group is rendered as “the other”) to recognition and celebration of diversity. Sexuality is a critical part of what it means to be human. Sexual diversity includes diversity relating to gender identity; sexual orientation (self-identity; desires/fantasies); sexual behaviour and expression of sexuality; and relationship status. A diversity framework reminds us to consider the continuum of sexuality issues for all people – not just regardless of their disability, but in addition to – or even as part of – their disability (Mackelprang & Salsgiver, 1999).

Similarly, a feminist framework is relevant to the oppression and discrimination experienced by people with a disability (Keith, 1996; Morris, 1996). Feminism comes with its roots in resistance to oppression (i.e. sexism), politicising the personal, prioritising choice and personal control and highlighting social barriers and inequities. A feminist perspective means focusing “not on our impairments – but on what is wrong with the way society is organised” (Morris, 1996, p. 11).

Feminist and diversity frameworks, together with a human rights perspective, highlight a range of socio-structural impediments. They also suggest priority actions for overcoming the disadvantage and discrimination faced by people with a disability in terms of their sexuality – including their gender, sexual identity, sexual safety and freedom of sexual expression.

Disability, disadvantage and discrimination

The World Bank estimates that 20% of the world’s poorest people have some kind of disability and tend to be regarded in their own communities as the most disadvantaged (UN, n.d.). The issues of inequality and discrimination for people with a disability create an additional challenge when also looking from a gender/sexuality lens – particularly when considering gender-based and sexuality-based discrimination and vulnerability to sexual victimisation.
Disability and gender-based discrimination

The most important aspect of sexuality that intersects with disability in terms of vulnerability to disadvantage is that of gender. In most OECD countries, there is a higher incidence rate of disabilities for women (UN, n.d.). Women with disabilities face multiple disadvantages, experiencing the added challenge of exclusion based on their gender and their disability. Women and girls with disabilities are particularly vulnerable to abuse. A small 2004 survey in Orissa (India) showed that virtually all of the women and girls with disabilities were beaten at home, 25% of women with intellectual disabilities had been raped and 6% of women with disabilities had been forcibly sterilised (UN, n.d.).

Disability and experiences of sexual assault and sexual victimisation

People with intellectual disabilities experience higher rates of sexual victimisation than those who do not have a disability (Furey, 1994), including multiple sexually abusive incidents (Sobsey & Doe, 1991). For example, Sobsey (1994) reported that 25% of girls and women with intellectual disabilities who were referred for birth control had a history of sexual violence. They are also less likely to obtain police intervention, legal protection or preventive care (UN, n.d.).

Any type of disability appears to contribute to higher risk of victimisation, but intellectual disabilities, communication disorders and behavioral disorders appear to contribute to very high levels of risk. Having multiple disabilities (e.g. intellectual disabilities and behavior disorders) results in even higher risk levels. Children with intellectual disabilities are also at risk of being sexually abused. A study of approximately 55,000 children in Nebraska (USA) showed that children with intellectual disabilities were four times as likely as children without disabilities to be sexually abused (Sullivan & Knutson, 2000).

Murray and Powell (2008) noted:

Adults with physical, intellectual or psychiatric disabilities face particular risks of sexual assault and exploitation. Research consistently finds that rates of sexual assault of people with a disability are much higher than the general population. (p. 1)

Compared to men, women are sexually assaulted more often – whether they have a disability or not (Morrison, 2006). However, men with disabilities are often overlooked. Researchers have found that men with disabilities are twice as likely to become a victim of sexual violence compared to men without disabilities (Davis, 1995/2005).

Based on a nationally representative survey, it is estimated that in Australia, approximately 20% of women and 6% of men will experience sexual violence in their lifetime (ABS, 2006). Australia does not currently have a standard national data collection that specifically measures experiences of sexual violence by people living with a disability. Nonetheless, a recent study conducted by the Australian Institute of Family Studies of police data from one jurisdiction – the state of Victoria – showed that just over a quarter of all sexual assault victims were identified as having a disability (Murray & Powell, 2008). Compared to the relatively low incidence of psychiatric and/or intellectual disability in the general population, the high proportion of sexual assaults of people with these disabilities in the data on reports
of sexual assault made to Victorian Police indicates they may be disproportionately vulnerable to sexual assault (see Table 1).

Criminal prosecution is difficult in the area of sexual assault – particularly when the victim has a disability. The groundbreaking analysis of police data from Victoria, Australia showed that of the 209 cases where the victim was identified as having a disability and where the case outcome was known, just under half (49.3%) did not proceed due to “no further police action”. Where the complainant had a psychiatric disability or a mental health issue, charges were laid in only 5 out of 130 cases (or 4.6%). Out of the 17 cases where the outcome was coded as a “false report”, seven involved complainants with a disability or mental health issue (Heenan & Murray, 2006; Morrison, 2008).

Out of the 209 cases, the victim was identified as having an intellectual disability in 1 in 4 cases ($n = 49$; or 6% of the overall sample). Cases involving victims with an intellectual disability were less likely to result in “no further police action” (31.3%) than other forms of disability, but slightly more likely to end in complaints being withdrawn (22.9%). They found that specialist sexual assault unit police were proportionately more likely, firstly, to believe in cases involving victims with an intellectual disability than other police – although levels of belief expressed by generic crime investigators were similar to the overall sample. Finally, they found that offenders were slightly less likely to be strangers (10.2%, compared to 16% for overall sample) and more likely to be an “other known person” (53.1%, compared to 20.0% for the overall sample) (Heenan & Murray, 2006; Morrison, 2008).

Another study (Wilson & Brewer, 1992, as cited by Murray & Powell, 2008) showed that adults with an intellectual disability were more than twice as likely to be victims of personal crime as other adults in the general population, but were 10 times more likely to the victims of sexual assault. They were also less likely to report the crime to police, especially if they were dependent on a carer who is the perpetrator.

Perpetrators of sexual assaults against people with a disability

Sexual assaults against women with a disability are perpetrated predominantly by men who are known to their victim, rather than strangers. These men fall into three main groups: (1) male co-residents in residential care facilities; (2) family members; and (3) staff in residential facilities and providers of disability services (Murray & Powell, 2008). This is consistent with the broader literature on women’s experiences of sexual assault, regardless of whether the victim has a disability.

Table 1. Disproportionate representation of people with disabilities in Victoria Police sexual assault data.

<table>
<thead>
<tr>
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<th>Australian Population (AIHW, 2006) (%)</th>
<th>Victoria Police sexual assault data (Heenan &amp; Murray, 2006) (%)</th>
</tr>
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<tbody>
<tr>
<td>Psychiatric disability and/or mental health issue</td>
<td>1.9</td>
<td>15.6</td>
</tr>
<tr>
<td>Intellectual disability</td>
<td>0.9</td>
<td>5.9</td>
</tr>
<tr>
<td>TOTAL for disabilities (approx.)</td>
<td>14.8</td>
<td>25</td>
</tr>
</tbody>
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Source: AIHW, 2006; Morrison, 2008; Murray & Powell, 2008.
Barriers to disclosure

Murray and Powell (2008) eloquently described some of particular barriers to making a disclosure faced by any victim of sexual assault:

If a disclosure is made, responses to this disclosure are often inadequate and may be harmful. A response to the sexual assault of an adult with a disability that is adequate is unfortunately still very rare, making addressing this issue a matter of continued urgency. (p. 1)

Barriers exist at three levels: societal, organisational and individual. For women with a disability, three societal barriers are (1) a lack of understanding about sexual violence; (2) people with disabilities considered to be “asexual” (Clare, 1999; O’Toole, 2000; Shakespeare, Gillespie-Sells, & Davies, 1996); and (3) myths that exist about women with disabilities, such as them being “promiscuous” or unable to be a “credible” witness (Murray & Powell, 2008).

Organisational barriers include: (1) poor – or absent – policies and procedures; (2) absent or poor promotion of violence prevention strategies; and (3) inappropriate responses to disclosures when they do occur (Murray & Powell, 2008). In relation to these organisational barriers, one of the reasons may be that key workers lack appropriate skills to develop, implement and promote policies/strategies or to respond appropriately to specific situations.

Finally, there are also individual characteristics of the person with a disability that may present a barrier or accentuate the other barriers identified above. These barriers at the individual level include a lack of basic knowledge about sexuality to recognise sexual assault for what it is. This is particularly for adults and young people with an intellectual disability. Secondly, communication difficulties may exacerbate disclosure difficulties. For example, where people with a disability rely on a communication facilitation tool, if it does not contain the appropriate vocabulary to describe sexual assault, they face an almost insurmountable problem in communicating their experience. Finally, where a perpetrator has a relationship in some way to the victim – such as when the perpetrator is a family member or a carer – it may increase the victim’s concerns about being believed or may exacerbate difficulties in making a disclosure in the first place (Murray & Powell, 2008).

Child disability and risk of child maltreatment

Systematic reviews of the literature have shown that for children/young people, having a disability is a risk factor for all forms of maltreatment (e.g. Black, Heyman, & Smith Slep, 2001a, 2001b; Black, Smith Slep, & Heyman, 2001). There are particularly strong associations between having an intellectual disability or learning disability and the risk of child sexual abuse. For example, Briggs (2006) examined the issue of learning disabilities and vulnerability to abuse and violence in Australia. She interviewed 116 students (aged 11–17 years; 61 females and 55 males) from special education units. The study confirmed the vulnerability of children with learning disabilities to the risks of drugs, violence, psychological bullying, pornography and sexual abuse. She found that both girls and boys reported significant levels of violence both at schools and in the home. Briggs argued that children with learning disabilities may be targeted because they were less likely than
others to (1) recognise abuse as wrong; (2) understand their rights and report abuse; and/or (3) be regarded as competent witnesses for court proceedings. Her findings suggest that children with learning disabilities require more vigilant and more intensive, explicit forms of protection than other children.

Studies show that children with disabilities are up to seven times more likely to be sexually abused than their non-disabled peers (Briggs, 2006). In her own research, Briggs reported that according to school counsellors, 44% of the girls with a learning disability were victims of (substantiated) sexual abuse, though only 32% of female respondents disclosed these offences to researchers. She also found that sexual abuse was equally common for boys and girls. Older youths were responsible for sex offences in a little over half of the cases (54%). Other offenders included stepfathers (four cases), mothers’ boyfriends (three cases) and family friends (six cases).

Disability and sex education

McCabe, Cummins and Deek (2000) examined the association between the sexuality and quality of life of 60 people with congenital physical disability, using the Sexual Knowledge, Experience and Needs Scale. Surprisingly, they found that there were few significant associations between the various domains of sexuality and the quality of life domains. The strongest associations were between sexual intimacy and importance of quality of life, rather than their current satisfaction with quality of life. They argued that the reason for this might be that people with physical disability have denied their sexuality due to the responses of carers, parents and the general community. Although there was an association between sexual intimacy scores and the importance people placed on their quality of life, this denial of their sexuality was responsible for the low association between satisfaction with quality of life and their knowledge, experience, feelings and needs in relation to sexuality domains.

There is a role to be played by parents, carers and broader family, as well as schools and institutions providing formal education and care, to recognise, prioritise and meet these information and support needs. However, McCabe et al. (2000) also found that parents, siblings and friends are not the main sources of sex education. This presents a challenge for young people with a disability in terms of whether disability limits their access to alternate sources of education. Children generally access sexuality education from family, siblings and friends, but also from the media, as well as formal sexuality education programs – particularly through schools. This highlights the importance addressing the sexuality education needs of all children and young people living with a disability. Since the 1960s this has increasingly been recognised by educators in Western countries, with the development of guidelines, curriculum and policies (Kempton & Kahn, 1991). However, the extent to which these are comprehensive, appropriate to the needs of all young people, such as same-sex attracted youth, or are sensitively implemented needs to be considered.

In another study, McCabe and Taleporos (2003) compared ratings of sexual well-being of 748 participants with a disability with 448 able-bodied participants. They found that:

... people with more severe physical impairments experienced significantly lower levels of sexual esteem and sexual satisfaction and significantly higher levels of sexual depression than people who had mild impairments to who did not report having a physical impairment. (p. 359)
From a sexual health and human rights framework, social attitudes and barriers set up by society are seen as the biggest limitation on the sexual functioning of people with a disability. Taleporos (2010) argued that adults with a disability have a range of rights including: to be treated as an adult; to knowledge; to be sexual and take risks; not be at the mercy of the individual sexual attitudes of different caregivers; to be safe from sexual abuse; and to have humane and dignified environments.

Safe sex is not solely about what two people do in the intimacy of a personal sexual encounter. It is also about creating a safe society so that sexual intimacy to which people freely consent – in all its diversity – can be enjoyed without fear, guilt or ignorance (Reynolds, 2007). This includes the sex lives and sexual expression of people with a disability.

**Fostering self-protection – teaching protective behaviours**

Children and young people with a disability not only need education about sexual development and sexual health, but also about sexual violence and safety issues. Mainstream “protective behaviours” prevention programs can be tailored, or new programs specifically designed to be accessible and relevant to people with a disability.\(^5\)

In Australia, Family Planing Queensland (2005) has developed a rules-based system for teaching protective behaviours programs to young people with disabilities. It has at its core a rights framework. Fundamental to implementing the system is that the young person is provided with a good understanding of their body, taught the ability to identify and label feelings (including warning signs) and what to do when unsafe. For example, their “NO, GO, TELL” system teaches children to be able to say NO, to be able to GO to a safe place; and to be able to TELL someone about what has happened.

Similarly, Sexual Health and Family Planning, Australian Capital Territory (2009) has developed “SoSAFE!” – a training program focused on social skills, sexuality education and social safety, in order to “reduce vulnerability to sexual abuse, and improve the quality of social life of people with a moderate to severe intellectual disability” (p.1). It teaches concepts around consent and understanding the graduated nature of developing relationships/intimacy. It tries to overcome some of the possible limitations of more cognitively-based programs that rely on people being able to identify and label feeling states correctly so as to invoke the desired protective behaviour response. Therefore, the system is also appropriate for those with moderate-to-severe intellectual disabilities.

As well as being vulnerable to abuse from others, children with a disability may be at risk of engaging in offending behaviour – particularly if they lack understanding of concepts like consent. For practitioners to be able to intervene appropriately, it is important to have a comprehensive understanding normative behaviour, in order to be able to see when children’s behaviours are problematic. The Flemish sexual health organisation “Sensoa” has some very useful, detailed descriptions of normative sexual behaviours (labelled as a “green flag”) and different degrees of problematic behaviour (labelled progressively yellow, red and black) (Frans, n.d.).

The limited availability of disability-specific sexuality information, education and support is compounded by the likelihood of what is available being heterocentric:
Disability oppression is institutionalised in our physical buildings and social processes but heterosexism and homophobia are also part of many disability and independent living organizations. (O'Toole, 2000, p. 216)

Disability and homophobia
Homophobia (or “sexual prejudice”; see Herek, 2004) is a kind of prejudice that in many ways parallels the experience of other minority groups, such as prejudice targeted at racial or religious groups or people with a disability. Rather than argue about the value (or the limits) of the analogy between sexual identity and disability status, instead, I wish to focus attention on the intersection between these two: the double-challenge that is faced by people who experience both homophobia and disability-based discrimination.

Looking at examples from other minority groups, there is the risk of one identity issue being rendered invisible as other identities take forefront position. Similar issues can be seen in the history of modern feminism, particularly in the USA, where strong tensions existed regarding the best way to fight discrimination and to achieve equality for Black feminist women – in terms of both individual identities and collective activism. For example, in terms of gay rights activism, the gender, ethnicity or ability/disability status of a Black lesbian with a disability should not have to “take a back seat”, in order to be able to fight for equality in terms of sexual orientation (Shakespeare et al., 1996).

When looking at sexual prejudice, researchers distinguish between “homophobia” and “heterosexism”. The latter is much more subtle, insidious and likely to have a negative impact on the degree to which therapeutic and research endeavors reflect people’s lived experience. Examples of heteronormative assumptions and bias against non-heterosexual identities (i.e. “heterosexism”) include: (1) framing same-sex attracted clients as the “other” (heterosexuality is seen not just as the statistical norm, but the standard, from which other sexual identities deviate); (2) using the term “gay men” to mean the divergent group, but simply saying “men” to mean all heterosexual (or non-gay) men; (3) referring to “women” or “men” when, in fact, the discussion or focus is only on “heterosexual” or “heterosexually partnered” women and/or men; and (4) ignoring same-sex attracted clients’ issues as peripheral to the mainstream (Higgins, 2007). Finally, therapists may have differential expectations for clients in relation to disclosing their sexual identity and behaviour. For example, therapists may not comparably expect that opposite-sex attracted clients declare their sexual orientation and “come out” as “straight” (Higgins, 2007).

When conducting therapy or research with people with a disability, there is a risk not only of employing heteronormative assumptions, but in fact of de-sexualising and ignoring the sexual identity, sexual behaviours, sexual health needs and sexual aspirations of people with a disability (Clare, 1999; Reynolds, 2007; Shakespeare et al., 1996). By not being explicit about the research participants, or client groups we are referring to, or by failing to acknowledge the differences that might exist, we potentially silence the needs and experiences of the diverse sexuality identities and experience of people with a disability (Higgins, 2007). We also silence the opportunities for understanding people’s hopes and experiences of positive sexual expression – in all its diversity.

In therapy, clients pick-up on small things – and this is particularly important when discussing sexuality issues with a client who has a disability. Therapists’ use of gender-inclusive language that does not make assumptions about relationship status
Conclusion

This article has briefly touched on some of the broader issues relating to sexuality for people with a disability, particularly, safety and freedom from sexual violence. However, the issues of sexual knowledge and experiences are also important in creating space for facilitating and celebrating positive, consensual sexual expression. Socio-structural disadvantage places people with a disability at greater risk of exposure to child sexual abuse, adult sexual assault. The data presented above have demonstrated the need for gender equality, sexual knowledge and awareness of protective behaviour strategies – as well as their rights for sexual expression and freedom from discrimination and harassment for people with disability. Specific attention needs to be paid to tailoring both strategies for prevention (e.g. teaching protective behaviours to children/young people with disabilities), as well as responses – particularly the barriers to disclosure of abuse/assault—in order to address the needs of people with disabilities.

Human rights and diversity perspectives have as their goal not only to meet the safety needs of people with disabilities, but also to create environments that foster positive expressions of sexuality – in all its diversity (Mackelprang & Salsgiver, 1999; O’Hare, 1999). For this to become a reality, there is a need for practical guides to assist therapists, educators and other disability workers to develop plans with their clients to facilitate such freedom of sexual expression. When considering the experiences, needs and rights of people with a disability, recognising multiple issues of gender, sex and sexuality is a challenge. Recognition of multiple identities, although a challenge, also provides an opportunity for welcoming and celebrating diversity and the freedom to be “non-traditional” (O’Toole, 2000). Recognising and balancing the complex and sometimes apparently competing self-identities and roles is complex, yet inherent within a truly human rights framework.

Notes

1. This paper is an edited version of an invited plenary address to the 19th World Congress for Sexual Health, Göteborg, Sweden, June 21–25, 2009. The Australian Institute of Family Studies is committed to the creation and dissemination of research-based information on family functioning and wellbeing. The views expressed in this paper are the author’s and may not reflect the Australian Government or Institute policy, or the opinions of the Director.
2. For the purposes of this paper, “disability” is used to refer to any long-lasting impairment that restricts everyday activities (ABS, 2004).
3. To be in a special education unit, the student is three or more years behind their chronological age group in their development and achievement and needs an individually planned curriculum.
4. SexKEn has 12 domains: friendship, dating/intimacy; marriage; body part identification; sex and sex education; menstruation; sexual interaction; contraception; pregnancy/child birth; STIs; masturbation; homosexuality.
5. In Australia, through its new Respectful Relationship Program, over the next five years the Australian Government will be evaluating best practice respectful relationships education.
programs with school-aged young people across the country. Programs will be tested in school and non-school settings and will address the diversity of young people, including those with intellectual disabilities. Existing programs – such as South Australia’s 2008 statewide roll out to all schools and pre-schools of their child protection curriculum, Keeping Safe – have materials that specifically address cultural and linguistic diversity, but not the needs of young people with an intellectual disability and those responsible for their care.

6. Although people may not exhibit fear or avoidant responses to gays and lesbians, their attitudes may be negative towards these groups.

7. However, it is important to acknowledge that there are criticisms of using sexual orientation and the “coming out” process an analogy for the identity politics and disclosure issues for people with a disability (for example, see Samuels, 2003; Shakespeare et al., 1996).

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References


