Disability and Sexuality

16

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16.1 Introduction

Disability does not discriminate. Disability is found all across the world in all cultures, times, spaces, and places. However, societies treat people with disability differently; some societies hold them in high esteem comparable to a deity while others actively exclude and/or reject them. In *Past and Present Perceptions toward Disability*, Chomba Wa Munyi describes how different cultures throughout time and place have treated people with disabilities [1]. Munyi "focused on cross-cultural factors that influence the development of perceptions toward children and adults with disabilities. Societal attitudes are significant since they determine to a large degree the extent to which the personal, social, educational, and psychological needs of persons with disabilities will be realized" [1]. Anthropologists, for example, have determined that disability was often seen as a bodily form of evil by some cultures while other cultures have seen disability as a means to pacify evil spirits [1]. In the early twentieth century in Ghana, people with developmental disabilities "were believed to be the reincarnation of a deity. Hence, they were treated with great kindness, gentleness, and patience" [1]. In ancient Greece, different approaches were evident: Spartans were ruthless and "ableism"—the discrimination and oppression of people with disabilities—was rampant throughout their society, with a person's worth based on capacity to serve in the military. In contrast, in Athens people with disabilities were pitied and afforded such amenities as state support and pensions [1].

With the rise of capitalism, globalization, neoliberalism, productivity-focused societies, and industrialization, disability has become synonymous with "a lack of contributing to society," being a burden, and/or generally being "less than" other

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people. Media, government, healthcare, education, social services, and policies in general are ableist and contribute to the exclusion of people with disabilities.

This chapter is written from the perspective of a disabled white settler, queer cis woman, an activist, artist, and educator who has firsthand experience with ableism and queer-phobia and whose intersectionalities, privileges, and experiences—including growing up in the USA and now living in Canada—inform life and interpretation. The chapter is not intended to be a comprehensive review of the topic, but rather a selective discussion of challenges faced by people with disabilities that are likely to inform patient–practitioner interactions.

According to the Canadian Survey on Disability, 2017, approximately 20% of the population has a disability [2]. In the USA the numbers are similar, with the 2012 analysis of the census reporting that "Approximately 56.7 million people (18.7%) of the 303.9 million in the civilian noninstitutionalized population had a disability in 2010"; however, 0.7% of that population (2.3 million of 324.2 million) is incarcerated, and a higher percentage of people with disabilities are represented in incarcerated populations. It is important to be culturally aware and sensitive to people with disabilities as they represent the largest minority population and, as the population ages, the number of people with disabilities will continue to grow.

20% of the population has a disability

[3]

16.2 Terminology

An important first step toward understanding people with disabilities is understanding terminology and labels.

16.2.1 Disability

When talking about disability, there is no ultimate definition or finite list of disabilities. Disability is a way to categorize people who have lived experiences of bodily difference. Historically, disability has been used synonymously with impairment or inability. However within this chapter we reflect on why it is important to not have a definition of disability and to not compile lists of diagnoses or categories. The Stanford Encyclopedia of Philosophy states "disability looks much like sex or race as a philosophical topic. It concerns the classification of people on the basis of observed or inferred characteristics. It raises difficult threshold questions about the extent to which the classification is based on biology or is socially constructed" [4].

Although "disability" itself is a contested term, being diagnosed and labeled as disabled in our society may hold value, especially when the label gives access to support systems. Financial support, educational support, employment accommodation, and housing are examples of assistance where medical professionals act as gatekeepers, as a physician's endorsement is necessary to "prove" disability. Conversely, some people may choose not to disclose a disability because of the stigma and fear of material consequence, such as not getting a job.

"Disability" is currently the most acceptable term to use. Some people prefer the person-first language of "people with disabilities" while others prefer identity-first language of "disabled person." Throughout this chapter, both are used interchangeably. However, it is best to ask people their preference or to match their language as they talk about themselves.

16.2.2 D/Deaf

There are two distinct definitions for the word deaf. If spelled with an uppercase D-Deaf, it refers to someone who identifies as being culturally Deaf (and uses American Sign Language [ASL] or another signed language to communicate), whereas lowercase d-deaf refers to a person with hearing loss. Deaf culture has a unique language, set of social norms, and heritage. Gallaudet University is an officially bilingual university in Washington, D.C., with the main languages being American Sign Language and English.

"American Deaf culture centers on the use of ASL and identification and unity with other people who are Deaf. A definition of the American Deaf culture that includes a set of learned behaviors of a group of people who are deaf and who have their own language (ASL), values, rules, and traditions was developed by Kannapel, a Deaf sociolinguist" [5]. *Deaf Culture: Competencies and Best Practices,* a paper written by a nurse practitioner, states, "To successfully navigate in the hearing world, deaf individuals must be able to read and write to bridge the gap when others do not know American Sign Language. Unfortunately, 90% of deaf children are born to hearing parents and do not develop language skills early on, which negatively impacts their ability to access health information and healthcare. Healthcare providers must ensure they provide culturally competent care and their practices accommodate the needs of deaf patients to mitigate communication barriers and ensure equitable care with positive health outcomes" [6].

Many D/deaf people use ASL-English interpreters to navigate the hearing world, which allows them to communicate in their preferred language of ASL. Additionally, "to successfully navigate in the hearing world, deaf individuals must be able to read and write the native language of the region to bridge the gap when others do not know American Sign Language" [6]. Some people with milder forms of hearing loss, or who communicate orally and by relying on their residual hearing, may identify as Hard of Hearing [7]. Some D/deaf people identify with being disabled but many do not.

16.2.3 Handicap

There are many theories and stories about the origin of the word "handicapped." Some argue the term was originally used to describe disabled people, post-war, that were begging on the streets in the UK with a "cap in hand." However, the Oxford English Dictionary indicates that the term was first used in the mid-1800s in sports to describe a temporary disadvantage, specifically with regard to horse racing. Throughout the early 1900s, the term handicapped started appearing in texts to describe individuals as "defective" [8]. Throughout the twentieth century, handicap became the widespread term used to label people with disabilities; its use was especially prominent with the increase of eugenics of disabled people. "Many disability rights advocates hate the term "handicap" [9]. Handicap is generally not an acceptable term any longer and should be replaced with "accessible," for example: the *accessible* parking spot, an *accessible* bathroom, etc.

16.2.4 Crip

Crip is the short form for the word Cripple. "The Anglo-Saxon words 'cripple' (crypel) and 'lame' (lam) date back to the early 9th century. Neither words were used abusively until the 17th century in the so-called age of enlightenment, when the UK led the world in slavery" [10]. The transition to using cripple as an offensive word occurred in conjunction with the dehumanization of people perceived as different or lesser. Cripple is generally not an acceptable term, although some disability rights activists have reclaimed the word Crip, using it only as a self-identifier and not in identifying other people.

Several prominent Crip activists include:

- Sins Invalid, "a performance project on disability and sexuality that incubates and celebrates artists with disabilities, centralizing artists of color and queer and gender-variant artists as communities who have been historically marginalized from social discourse" [11]. Sins Invalid coined the term disability justice. "Disability justice is a multi-issue political understanding of disability and ableism, moving away from a rights based equality model and beyond just access, to a framework that centers on justice and wholeness for all disabled people and communities" [12].
- Mia Mingus, writer and community organizer for disability justice.
- Sarah Jama, founder of Ontario Disability Justice Network djno.org

16.2.5 Ableism

Ableism is a form of discrimination and oppression. It is "the practices and dominant attitudes in society that devalue and limit the potential of persons with disabilities. A set of practices and beliefs that assign inferior value (worth) to people who have developmental, emotional, physical or psychiatric disabilities" [13]. Ableism is rampant

throughout all parts of society and perpetrated by the media and social institutions. Parsons et al. explain, "[i]ndividuals with disabilities are largely ignored by mainstream media. When shown they are often shown as dependent and asexual" [14].

Medical Ableism occurs when doctors, nurses, administrators, and other healthcare professionals treat people with disabilities as inferior and invisible, and devalue their worth, potentialities, and bodily autonomy. Medical ableism can also exist within the physical environments of healthcare settings, such as a sexual health clinic not having a Hoyer lift that may be needed to perform an external visual exam or swab on someone with physical differences. Since the medical model of disability is the dominant model, often the medical system may be an individual's first encounter with the label of disability. This first encounter may play a critical role in how individuals see their own disability. Healthcare providers may inadvertently shape a person's self-worth if they imply that the disability diagnosis is hopeless, negatively life altering, or catastrophic, or if they are non-encouraging in their approach. The healthcare system often focuses on cures and quick fixes, which are sometimes out of reach for people with disabilities and chronic health conditions. Also the need to cure or fix disability is problematic in itself as it assumes that people with disabilities cannot be happy and live fulfilling lives in their current condition.

Medical ableism, combined with other forms of societal ableism, can lead to "internalized ableism." Internalized ableism occurs when people living with a disability feel bad about themselves, and hold the belief that they are inherently less worthy or valuable than their able-bodied peers. This low self-esteem can lead to many negative health outcomes, with many people with disabilities avoiding doctors or health professionals in order to avoid medical ableism. Internalized ableism can also lead disabled people to compare their worth to other disabled people and create negative competition between them (see cartoon below).
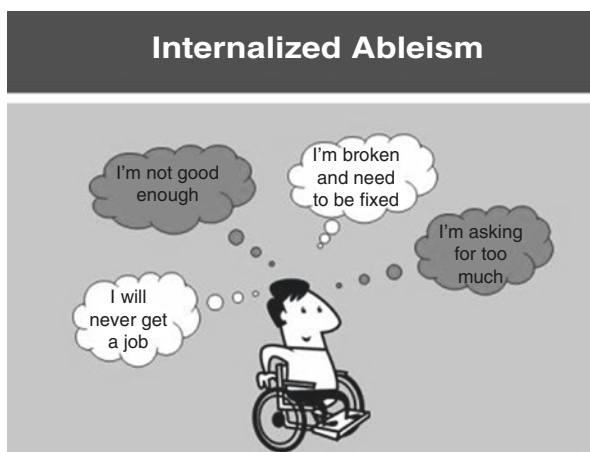
[15]

Maria R. Palacios, a poet, author, disability advocate, spoken word performer, disability educator, workshop facilitator, and professional presenter uses words to

empower and educate. Her poem on internalized ableism exemplifies the intensity it can have on people's lives as seen in this excerpt [15].

The Other Side of Ableism
By Maria R. Palacios
Internalized ableism is
believing that our bodies
are incapable of pleasure,
allowing others to define how we should define
pleasure
because many people believe
broken bodies don't feel
broken bodies don't give,
broken minds don't understand
Love,
intimacy
sensuality
Internalized ableism is
denying our own sexuality,
or turning able-bodied lovers into heroes for sleeping with us
because sex with a disabled person is some sort of sacrifice,
something that deserves respect
or an Amen
because sex with a cripple is got to earn you some heaven brownie points
even at the risk of sin.

To read the whole poem: go to: https://cripstory.wordpress.com/2017/07/06/the-other-side-of-ableism/.

16.3   Approaches Toward and Categories of Disabilities

16.3.1 Medical Model of Disability

The medical model of disability views impairment of the individual as the problem. Disability is something to cure, fix, hide, or manage. This model has its roots in the biomedical model of the body and links diagnosis to disability, with a need to fix it in order to fit into "normative" ideals.

16.3.2 Social Model of Disability

Disabled activists created the social model of disability as a theory of disability in the 1980s in the UK. The social model focuses on barriers created by society, both physical and attitudinal, that contribute to the disability of people with bodily

differences. This model "focuses on the concept that disability is not an individual possessive trait but rather an external socially mediated phenomenon, which can be challenged and changed" [16].

Below is a cartoon that visually explains the main difference between the medical and social models of disability. Often the fixes to society's barriers that remedy the exclusion they create for people with disabilities result in better access for all individuals and do not have to be seen as a fix that is solely for the use of people with disabilities but one that can be used by everyone. A ramp, for example, can be used by people in wheelchairs, as well as people who would otherwise walk upstairs. Disability scholars prefer to refer to disabilities as a combination of physical difference and societal barriers. Societal barriers lead to disability; disability is a result of societal barriers.

[17]

16.3.3 Categories of Disability

Most disability scholars reject the ways in which society categorizes disability, focusing on the medicalization and diagnosing of individuals. But because the readership of this text includes a medical audience, some of the more generalized categories of disability are listed here because disability is often only seen in terms of physical, visible differences, whereas many other kinds of diagnoses and experiences can also be part of a disability categorization. These categories may overlap and people may fall into multiple disability categorizations. The disability may be present from birth, develop in life, be caused by an injury or accident, or a result from aging or inadequate care.

- Episodic Disabilities
- Intellectual and Developmental (IDD)
- Invisible
- Mobility/Physical

- Psychiatric/Mental Health
- Sensory

16.4   Intersectionality

Kimberle Crenshaw, a black feminist scholar, coined the term "intersectionality" in 1989. Intersectionality "has become the predominant way of conceptualizing the relation between systems of oppression which construct our multiple identities and our social locations in hierarchies of power and privilege" [18]. In particular, Crenshaw created the term intersectionality as a metaphor to explain the multiplicity of oppression; she did not just experience sexism alone or racism alone but rather these forms of oppression interlocked and worked together.

When acknowledging the oppressions that disabled people face, an understanding of intersectionality is important. Disabled people have multiple identities and may face discrimination differently than other people. The Magic Wand, a poem by Lynn Manning, a Black blind man, addresses the intersectionality of disability and race.

The Magic Wand
A poem by Lynn Manning
Quick-change artist extraordinaire,
I whip out my folded cane
and change from Black Man to 'blind man'
with a flick of my wrist.
It is a profound metamorphosis –
From God-gifted wizard of round ball
Dominating backboards across America
To God-gifted idiot savant
Pounding out chart busters on a cocked-eyed whim;
From sociopathic gangbanger with death for eyes
To all-seeing soul with saintly spirit;
From rape deranged misogynist
To poor motherless child;
From welfare rich pimp
To disability rich gimp;
And from white Man's burden
To every man's burden.
It is always a profound metamorphosis –
Whether from cursed by man to cursed by God,
Or from scripture condemned to God ordained.
My final form is never of my choosing;
I only wield the wand;
You are the magician.

[19]

Parsons, Reichl, and Pedersen address the intersectionality of women with disabilities: "women with disabilities are marginalized both because of their status as disabled and also because of their gender. The cross section of discrimination based on both disability and gender has serious implications for women with disabilities in that they are effectively rendered powerless by society" [14]. Women with disabilities are many times more likely to be victims of sexual violence than able-bodied women (see Sexual Violence section below).

16.5 Healthcare Issues

16.5.1 Disability-Poverty Cycle

Poverty can lead to disability and disability can lead to poverty, a cycle that is hard to break. Poverty leads to disability through lack of proper housing, nutritious food and clean water, and access to consistent healthcare. Disability contributes to or increases poverty levels due to discrimination and barriers that lead to less access to education, proper housing, and employment opportunities, along with increased social isolation. According to the 2017 Canadian Survey on Disability "The highest rates of poverty (for those aged 15 to 64 years) were among those with more severe disabilities who were living alone…6 in 10 were below the poverty line" [20]. According to a 2012 report on the 2010 US Census, "[j]ust as earnings and income were lower for people with disabilities, poverty rates were higher. Approximately 28.6% of people aged 15–64 with disabilities were in poverty [compared to] 14.3% of people with no disability" [21].

[3]
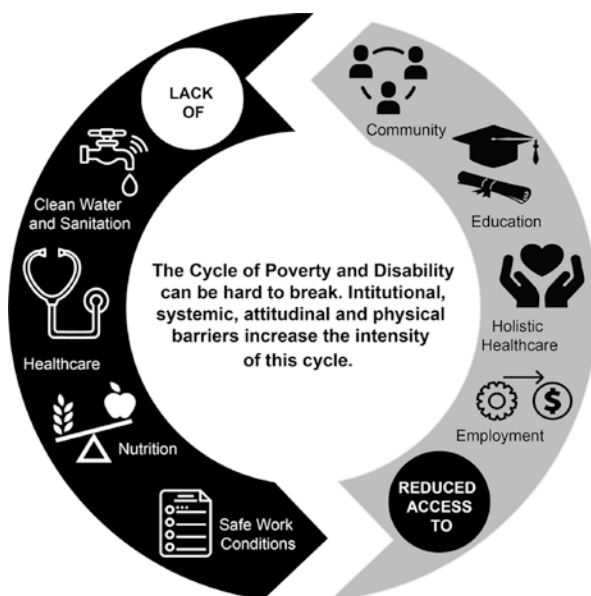
16.5.2 Lack of Care

Often people with disabilities are less likely to be taken seriously when receiving health care. Unfortunately, medical professionals sometimes assume they know more about a disabled person's body than the person him/herself. In addition, ailments may be overlooked or considered symptoms of one's disability rather than viewed as a legitimate concern. For example, someone who has a physical disability may be ignored when reporting symptoms of anxiety, as the physical disability is seen as a bigger "issue" than the mental health concern. People with disabilities may be denied some forms of health care because of their disability, for example, contraception or STI testing. Healthcare providers often assume they know what is best for their patient rather than listening to the wants and needs of the person. This is particularly the case for transgender people with disabilities who may be denied access to gender transition-related care because of their disability. In the article *Navigating the Twists and Turns of Healthcare as a Trans Disabled Person*, the author interviews several trans-disabled people, one of whom remarks, "There's just the CONSTANT tension of like, you can find transition-related healthcare that is clueless about your disabilities, or you can find healthcare treating your disabilities that is clueless about trans identities" [22].

16.5.3 Language and Communication

A Deaf person may request an ASL interpreter to ensure clear communication between the individual and the healthcare worker. The Deaf person's preferences regarding the choice of interpreter need to be considered and the interpreter needs to be knowledgeable and competent in interpreting topics related to sexual health. Interpreters should be trained professionals who are members of their professional association and therefore bound by a code of ethics, including the requirement to keep all information confidential. As such, the client/healthcare provider relationship should not be impacted by the presence of an interpreter beyond the role of facilitating communication. The National Association of the Deaf reminds us, "service providers may mistake cultural, language and communication issues for developmental delays or mental illness" [23]. If an interpreter is not available, the healthcare provider may be able to use other ways to communicate such as by texting, realizing such communication is in a language (e.g., English) which may not be the Deaf person's primary language (e.g., ASL).

Some people with disabilities have advocates that translate their speaking so that healthcare workers can understand them; this individual may be a personal support worker or another caregiver, a Deaf/Blind intervener, or an advocate who attends appointments with the person with the disability. Depending on the relationship between the person with a disability and the advocate, sensitive topics such as sexuality, sexual practices, and healthcare questions may be avoided due to awkwardness or the desire to maintain a positive relationship. Such avoidance may be

especially likely if the advocate is a parent or has a certain level of power over the person with a disability. See the following section on "Caregivers and Power Dynamics."

Several alternative types of communication include:

- Communication boards (manual or electronic) which involve pointing to words or pictures to communicate.
- Text-to-Speech devices.
- Tactile ASL or Hand-over-Hand ASL (for Deaf-Blind people who prefer to communicate using ASL).
- Speech Reading.
- Print on Palm, in which the person communicating with the deaf-blind person prints large block letters on the other person's palm. Each letter is written in the same location on the person's palm. This is frequently how deaf-blind people communicate with the public.

There are many other forms of communication and, as culture and technologies develop, communication options will also continue to develop.

16.5.4 Caregivers and Power Dynamics

Since many people with disabilities rely on others to help with daily living tasks, depending on the nature of their disability, these caregivers hold power over them. Often caregivers are parents or other family members, or in some cases personal support workers or other paid staff. Caregivers may have predetermined hopes and dreams for their loved one or, conversely, they may have already assumed how their life will play out. Often these assumptions are rooted in ableism, involve power dynamics, and may originate from the media or public institutions. In addition, not being able to speak for oneself, having one's needs seen as part of a disability and thus invalidated, and the assumption of lack of agency by caregivers not only close off opportunities for people with disabilities but may lead to questioning their judgments in ways that would never occur for able-bodied persons.

16.6 Issues Surrounding Sexuality

A 2010 research study that aimed to "describe the current societal perceptions and attitudes surrounding sexuality and disability" found five main attitudes regarding sexuality: asexuality/stigmatization, heteronormative ideas of sex and naturalness, lack of emphasis on sexual rights, lack of information and sex education, and visible versus invisible disabilities. Asexuality is a spectrum where the person may not feel any sexual desires or have any wish to pursue sexual activities. "Heternormativity" is the idea that being heterosexual is the natural and "right" way to be, including the

belief that sex should include penis/vaginal intercourse. People with disabilities face countless barriers to sexual expression and sexual fulfillment within ableist cultures [24].

16.6.1 Sexuality

People with disabilities have the same range of sexuality/sexual interests as able-bodied people. However people with disabilities are more often seen as asexual or are infantilized. Kaufman, Silverberg, and Odette debunk common myths about people with disabilities and sex. Specifically, the myth that all disabled people are asexual comes from the idea that people with disabilities are helpless, like children. As the authors argue, "If you can't feed yourself or need help wiping your ass, or need help getting in and out of a car, you are considered a child. Thus they (society-author's note) deny our sexualities" [25]. Since this myth is prevalent and people with disabilities are often at the whim of caregivers or parents, sexuality or sexual expression may not be expressed until much later than for peers. People with disabilities are often actively denied access to their own sexuality, as it is not seen as part of the human needs for living well. Disabled people are often not seen as desirable, as they fall victim to the same stereotypes about sex that other people do, namely, that sex has to be spontaneous and is only for attractive young able-bodied people. Esmail et al. explain, "individuals with disabilities are commonly viewed as asexual due to a predominant heteronormative idea of sex and what is considered natural. A lack of information and education on sexuality and disability was a major contributing factor toward the stigma attached to disability and sexuality" [26].

16.6.2 Body Image

Internalized ableism affects negative body image as well as all the other forms of discrimination and oppression. People with disabilities have complicated relationships with their bodies that are often shaped by medicalization, sexual violence, ableism, less access to education, lack of autonomy, and bodies as sites of many kinds of trauma. Since sex is often a physical act (although phone sex or sexting can be forms of sex as well), the complicated relationship persons with disabilities have with their bodies leads to complicated relationships regarding sex.

16.6.3 Lack of Information and Sex Education

Sex education, when it does occur in school systems, is often connected to physical education (PE) or gym classes. Since many people with disabilities are excluded from PE classes, they may be excluded from sex education, even when they are a part of the "regular" education curriculum. In addition, students in "special

education" programs for individuals who are developmentally delayed are often excluded from the sex education curriculum. This situation often occurs not because these students do not need this information but because parents and teachers may be uncomfortable with the idea that persons with disabilities also have sexual needs. Furthermore, when students with disabilities are included in a classroom where sex education is taught, they may find the information useless or not relatable because disabled people are not represented in the curriculum.

> **Case Study**
> "I did not have sex ed classes consistently until graduation, but when I did I was not deliberately excluded. That being said, the focus was on discussions of heterosexual sex and issues related to it so I never felt that I was learning anything, which could be applied, to my life. That is to say nothing of the fact that all of the discussions…focused on nondisabled bodies. Lastly, right from the get go in seventh grade when sex ed began, it felt like my presence in the class was mandatory but that any opinions or questions I might have were generally ignored, maybe owing to the fact that the teacher assumed sex would not be a part of my life at any point."
>
> – undergraduate student with disabilities

16.6.4 Sexual Violence

People with disabilities report higher rates of sexual violence than people without disabilities. According to a Stats Canada's 2014 report, "Women with a mental health-related disability (131 per 1000) or a cognitive disability (121 per 1000) were more likely to report having been a victim of sexual assault, compared with women without a disability (29 per 1000)" [27]. In this regard, Kaufman et al. state it is "clear that there is a much higher than average risk of sexual abuse for people living with disabilities. The numbers from different studies vary, but the risk for women with disabilities is anywhere from two to ten times greater than that found in the general population. The risk is higher for men as well, but reliable information is even more scarce than for women" [25]. It is also noteworthy that many people with disabilities cannot report sexual violence, as their caregiver may be the person abusing them.

16.6.5 Social Isolation

Ableism, and how society creates and maintains barriers for people with disabilities to connect, can lead to social isolation. Not only is access to other disabled people limited, but institutional, environmental, and social barriers lead to isolation from most forms of social interactions. One research study on disability, social isolation, and loneliness found that "61% of disabled participants acknowledged that they spent most of their time alone, compared with 28% of the nondisabled group" [28].

The internet and social media in particular have played a big role in reducing isolation for many people with disabilities. Additionally, dating apps have been beneficial for meeting others without the barrier of having to meet initially in a physical space.

16.6.6 Sex Workers

Sex work and the sex industry can be a valuable avenue for sexual fulfillment for people with disabilities. However disabled people also face "substantial barriers as clients trying to access sex, sexual services and support" [29]. Criminalization and stigmatization of sex work and hiring sex workers has a negative impact on sex workers and clients with disabilities.

It is also notable that due to the nature of sex work, a large percentage of sex workers have disabilities, in particular, invisible ones [29]. Sex work can be flexible and has relatively high pay for a minimal amount of hours, which makes this type of work ideal for some people with disabilities. One Canadian dominatrix reports, "the sex industry has provided the necessary means to support herself," providing an example of the resiliency that people with disabilities show when finding work that they have control over [29].

16.7   Practical Implications for Healthcare Providers

Understanding the issues people with disabilities face will help healthcare providers take a more patient-centered approach to working with such individuals. Health providers need to become allies to people with disabilities, as people with disabilities need the support and advocacy of their healthcare providers in order to gain access to health care in general and sexual health care in particular. Having open and honest discussions—including recognizing one's potential biases and limited knowledge—helps build needed trust.

16.7.1 Commitment to Respect and Dignity

One of the core elements of inclusion and disability justice is respect and dignity. Healthcare providers should listen carefully to their clients/patients, take their word as truth, not interrupt, and especially important, not make assumptions regarding disability and sexuality. People with disabilities do have sex, although it might not conform to traditional expectations and may extend substantially beyond the more traditional repertoire of sexual activities. The healthcare provider should also consider—and staff should be informed—that booking additional time might be beneficial, especially if the person's communication style takes longer (see previous section on Communication).

16.7.2 Understanding the Possible Need for Planning Sex and Using Sex Toys

Sex toys, vibrators, and props/pillows can be very helpful to enhance pleasure, especially for people with disabilities who may have weak motor skills or range of motion. Additionally, sex is often thought of as spontaneous, but planning can be very useful and help people with disabilities fulfill their desires. Healthcare providers can show support by encouraging their clients to plan their sex, map out their own desires, and learn to talk about what they want and how to make it happen with their partner(s).

Case Study
As a queer disabled person, I love planning and scheduling my sex. It makes the act of sex seem that much more purposeful and important to me. I used to crave these able-bodied notions of spontaneity, but very quickly realized that planning makes sex better. It allows me to have agency of my experience, and I get excited when I can write down in my day planner, that on this day I get to have sex. Planning sex allows for me to work with attendant care so that I can feel fresh, vibrant and sexy prior to the hook up, and that gives me a confidence spontaneity never could.—Andrew Gurza, creator of podcast *Disability After Dark*

16.7.3 Honoring the Resilience and Creativity of Persons with Disabilities

Disability can lead people to become expertly resilient and the healthcare provider should honor this capacity, encouraging persons with disabilities to formulate their own solutions and recognizing these strengths without being patronizing.

16.7.4 Taking the Time to Learn a Little Bit More

Many resources discuss specific disabilities and sexuality. The healthcare provider can better advise clients with disabilities regarding sexual issues/treatments by consulting the following:

1. *The Ultimate Guide to Sex and Disability*, by Miriam Kaufman [25]. This book, written by a medical doctor, a sex educator, and a disability activist, is an open and honest how-to focused book. The book includes disability-specific sections as well as encouragement, support, information, and advice about all things related to sex and disability. Although the book's audience is people with disabilities, it could also be useful for healthcare professionals.

2. *Sexuality and Disability: A guide for everyday practice*, by [30]. Abingdon: Radcliffe Medical Press. This book's audience is healthcare practitioners and social workers and includes diagnoses, specific treatments, and advice for people who may feel uneasy addressing topics of sexuality with their clients.
3. Communication advice: This URL from the National League for Nursing provides a wealth of information regarding communicating with persons having disabilities, both generally and for specific disabilities. It also provides links to other useful resources. http://www.nln.org/professional-development-programs/teaching-resources/ace-d/additional-resources/communicating-with-people-with-disabilities.

16.8   Summary

People with disabilities face many challenges in their everyday lives. Healthcare providers should be aware not only of these challenges, but also of their own cultural biases—reflected in ableism—that may affect their assumptions and interactions with this population of clients. Medical ableism can lead to distrust of healthcare providers by the disabled, and result in a lack of care-seeking within this population. Intersectionality needs to be recognized, along with the fact that sexual fulfillment for people with disabilities is often negatively impacted by mitigating experiences such as poor body image, lack of sex education, and higher rates of sexual violence and social isolation. Specifically, healthcare providers should not add to the challenges of disabled persons, but rather should become their allies in achieving a healthy and satisfying sex life to the extent that clients seek such assistance, as those with disabilities have a right to bias-free and adequate healthcare, as well as acceptance—and guidance when appropriate—in the expression of their sexuality.

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