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Disability and the male sex right

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SYNOPSIS

Access to prostituted women is increasingly justified by disability charities and services on the grounds of the sexual rights of the disabled. In Australia, for example, disabled men form a niche market for the legalised prostitution industry. Male sexuality is constructed out of male dominance and is likely to manifest the eroticisation of hierarchy and the idea that males should have the sexual right to access the female body. This model of sexuality poses problems for all women in the form of sexual harassment and violence, pornography and prostitution. It poses particular problems for women with disabilities who are more vulnerable to sexual assault and harassment from carers and disability fetishists. The sexual rights idea does not generally take gender into account. Thus sexual rights for men with disabilities can include the right to pay for or demand sexual servicing from women in prostitution, nursing or caring work. This article seeks to disaggregate the notion of sexual rights according to gender.

Introduction

In this article I will look in an exploratory way at several issues concerning disability and sexual exploitation that might seem at first to be distinct. They include the sexual abuse of women with disabilities and the prostitution of women with disabilities, the exploitation of prostituted women by men with disabilities, and men's sexual fetishising of women with disabilities. The connecting factor is the sexuality of male dominance. In relation to sexuality, disabled men may pursue interests that are in stark contradiction to those of disabled women. Organisations supporting men with disabilities campaign for their sexual rights which may mean using pornography and prostituting women. These forms of sexual exploitation teach and represent an objectifying sexuality. It is precisely this form of sexuality that disabled women suffer from, in the form of unwanted sexual contact and the fetishising of disability. It is important to disaggregate the interests of men and women when considering the issue of disability and sexuality.

Feminist disability theorists have been working for three decades to provide an understanding of disability which takes gender into account (Morris, 1989; Fine & Asch, 1988; Matthews, 1983). They have pointed out that women with disabilities can be seen as at least doubly disadvantaged i.e. by discrimination on the grounds of gender and disability, and often by a third form of exclusion and discrimination in the form of racism as well (Begum, 1992). They have shown that the model of rehabilitation of people with disabilities that the medical model of disability promotes, has a male body and male sexuality in mind. Rehabilitation programmes seek to cultivate 'competitive attitudes' and address 'concerns about male sexuality'. They are about 'enabling men to aspire to dominance notions of masculinity' whilst ignoring the needs of disabled women (Begum, 1992: 72). Feminists have criticised the understanding of sexuality that is applied to women with disabilities by doctors, in which they are seen as functional if they have a usable vagina for a male partner's satisfaction. This is a very masculine model which does not countenance women's pleasure, the clitoris, and more imaginative approaches which do not have to be focused on penis in vagina sex, or even heterosexual (Titchkosky, 2000). Feminist approaches to disability have given little attention, however, with the notable exception of the work of Amy Elman, to the need to disaggregate the concept of the sexual rights of the disabled (Elman, 1997).

Feminist theorists have also criticised the limitations of the 'social model' of theorising disability. This article starts from the understanding that disability is to a large extent socially constructed (Oliver, 1990), an approach that has been termed the 'social model' of theorising disability (Lloyd, 2001). According to this approach the problems that women

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with disabilities face are not the sad but inevitable result of a biological or acquired flaw, and an individual responsibility. The disabled experience problems such as violence and penury because the societies in which they live do not acknowledge persons with disabilities and want them to be 'out of sight, out of mind' (DVIRC, 2003). The values of capitalist societies based on male dominance are dedicated to warrior values, and a frantic able-bodiedness represented through aggressive sports and risk-taking activities which do not make room for those with disabilities. Feminist critics have pointed out, however, that the social model can reproduce a form of mind/body split, by downgrading the lived experience of the body which is not merely a social construction. It can serve to obscure the very real experiences of pain, for instance, that women with disabilities face (Titchkosky, 2000). Women's physical experience of impairment will affect the ways in which they are vulnerable to men's violence, and the forms that this takes. But sexual violence against women with disabilities is also a classic example of how the problems of disability are socially constructed. This violence is founded on the male sex right, a construction of male dominance, and enabled by economic, mobility and emotional factors that women with disabilities suffer as a result of the obstacles placed in the way of their integration into an able-bodied world.

The sexuality of male dominance is based upon what the political theorist, Carole Pateman, calls the 'male sex right' (Pateman, 1988). This is the privileged expectation in male dominant societies that men should have sexual access to the bodies of women as of right. Such societies organise delivery of this access to men, and the removal of obstacles, in various ways. This can be through the provision of legalised prostitution or the tolerance of illegal prostitution. It can be through enabling the creation of other aspects of the prostitution industry such as pornography, strip clubs and sex phonelines (Jeffreys, in press-a). It can be through child marriage in traditional societies or the early sexualisation of children in the west (Moschetti, 2006).

In relation to disability this law of the male sex right leads men and boys to sexually abuse women, girls and boys made vulnerable to them by virtue of their dependence on male carers, or through institutionalisation. It leads to the provision of prostituted women to men with disabilities (see Sullivan, 2007), the provision of what are euphemistically called 'sex surrogates', or even the requirement that nurses and carers masturbate men with disabilities, which is called 'facilitated sex' (Earle, 2001; Davies, 2001). It also leads men who fetishise and get sexually excited by women's disabilities to harass women amputees and seek sexual access to women with disabilities through various forms of exploitation and trafficking, the mail order bride business, prostitution and pornography (Elman, 1997).

The fetishising of disability comes from the way in which, under male dominance, male sexuality is constructed to eroticise hierarchy and to objectify. As the radical feminist legal theorist, Catharine MacKinnon, points out, gender is a hierarchy, and it is the eroticising of male dominance and female subordination that forms the foundation of what is commonly understood as sex in male dominant culture (MacKinnon, 1989; Jeffreys, 1990). The eroticising of hierarchy by men is not restricted to gender. Other forms of hierarchy are eroticised too, such as age in paedophilia, race in relation to the racist sexual stereotyping that underpins the male interests of using exotic prostituted women, such as those who have been trafficked or are available in sex tourism destinations (Jeffreys, 1997). Disability provides another hierarchy for eroticisation. Women with disabilities offer the double delights of gender inequality and disability as sources of sexual satisfaction to dominant male sexuality. Thus some men come to fetishise women's disability (Elman, 1997). Some of those men who sexually fetishise disability seek to become disabled themselves, usually through amputation of limbs (Elliott, 2003). This condition is commonly called amputee identity disorder or BIID (Body Identity Integrity Disorder). The power and influence of the male sex right is indicated in the fact that a movement to get amputation of healthy limbs available to such men is under way with the support of respected psychiatrists and surgeons, such as the editor of the US Diagnostic and Statistical Manual, Michael First (First, 2004).

Despite the rather clear differences in the ways in which male and female sexuality are constructed under male dominance, when disability studies have approached the issue of sexuality they have not usually disaggregated the interests of women with disabilities from those of men with disabilities. When sexuality is addressed in the literature this often fails to mention the problem of sexual exploitation that women with disabilities face. The definition of sexual exploitation that I use comes from the United Nations Draft Convention Against Sexual Exploitation (1991) in Defeis (2000, p. 335).

> Sexual exploitation is a practice by which person(s) achieve sexual gratification, or financial gain, or advancement, through the abuse of a person's sexuality by abrogating that person's human right to dignity, equality, autonomy, and physical and mental wellbeing. (For discussion of this Draft Convention and the text see: Defeis, 2000).

Prostitution and pornography are included in this understanding as sexually exploitative practices. In this article sexual exploitation means gaining access to sexual use of a person's body by means of any form of unequal power e.g. payment, force or its threat, emotional manipulation by someone in a position of power, superior age or knowledge. It is distinguished from wanted sexual interaction with equal desire and pleasure for both partners, freely entered into.

Unwanted or coercive sex in relationships and from carers

International research suggests that women with disabilities suffer significantly more from sexual violence than other women (Elman, 2005). In general women with disabilities are 'assaulted, raped and abused at a rate of at least two times greater than women without, yet are less likely to receive assistance or services if they experience violence' (DVIRC, 2003, p. 12). Some forms of abuse are unique to women with disabilities. Sexual abuse of a woman with a disability may include, for example, forced sterilisation or forced abortion (DVIRC, 2003: 12). Lack of sex education for girls with disabilities can contribute to their vulnerability to male sexual use. Also women with disabilities, 'face alarming rates of violence from paid and non-paid carers' (DVIRC, 2003: 23).

Feminist scholars have paid considerable attention to the problem of unwanted sex in the relationships of able-bodied women in the last decade (Jejeebhoy, Shah & Thapa, 2005; Gavey, 2005; Phillips, 2000). The difficulties for women with disabilities, however, are likely to be greater than those of girls and women without for several reasons. These include self esteem and body image problems which may make them more easily manipulated emotionally (Hassouneh-Phillips & McNeff, 2005). Physical or intellectual disabilities, mobility problems or dependence upon carers, make it more difficult for them to protect themselves against unwanted touch and sexual contact. Women with high degrees of physical impairment, may suffer disproportionately low 'sexual and body esteem' (Hassouneh-Phillips & McNeff, 2005: 227). A study of women with high degrees of physical impairment found that they were vulnerable to 'getting into and staying in abusive relationships over time' because they saw themselves as sexually inadequate and unattractive (Hassouneh-Phillips & McNeff, 2005: 227). These women are less likely to marry than other women with disabilities and this may make them more likely to suffer abuse rather than face loneliness and lose the person who cares for them 'For some women, these disadvantages translate into an increased tolerance of abuse in intimate partner relationships out of fear that no one else will want or care for them' (Hassouneh-Phillips & McNeff, 2005: 229).

Research shows that 40–72% of women with physical disabilities 'have been abused by an intimate partner, family member, caregiver, health care provider, or other service provider' (Hassouneh-Phillips & McNeff, 2005: 229). These statistics cover abuse in general and make no special mention of sexual abuse, for which figures are difficult to obtain. But one particularly poignant quote from the 2005 study suggests that women with disabilities might allow men to engage in abusive sexual behaviours towards them out of a desperate desire to hold onto the relationship, 'my main thing that I think my relationship with my men is to please my man… and so I do everything that I can do to please. Because it's constantly in my head — am I pleasing him sexually?' (Hassouneh-Phillips & McNeff, 2005: 237). The prolonged exposure to abuse that some women with disabilities suffer because of the restrictions to mobility and lack of alternatives they suffer in a society which is not organised to ensure their integration, leads to increased risk for 'negative health outcomes including injury, chronic pain, depression, post-traumatic stress disorder, substance abuse, homicide and suicide' (Hassouneh-Phillips & McNeff, 2005: 237).

Douglas Brownridge's study in *Violence Against Women* on partner violence against women with disabilities found that the women had a 1.4 to 1.9 times greater likelihood of physical violence than other women over the previous 5 years, with the greatest disparity in relation to 'more severe forms of violence' (Brownridge, 2006: 812). But sexual violence was much the most common form of violence they experienced. Women with disabilities were three times more likely to report 'being forced into sexual activity by being threatened, held down, or hurt in some way' (Brownridge, 2006:812). The research found that the male partners of women with disabilities were 1.5 times more likely to 'engage in proprietary behaviors' than those of other women (Brownridge, 2006: 818). The increased risk of violence suffered by the women with disabilities in this study is attributed to 'ideologies of patriarchy and male sexual proprietariness which were particularly strong in these relationships' (Brownridge, 2006: 818). Brownridge's research focused on partner violence and the researcher was careful to point out that women with 'developmental disabilities' and the most severe forms of disability, were less likely to be partnered, though research suggests that they receive a particularly severe degree of violence. As Amy Elman, whose earlier work was the first to examine the issue of men's sexual fetishising of women with disabilities (Elman, 1997) has commented in her more recent work, it is important to pay attention to distinguish the ways in which women and girls are sexually exploited in relation to different forms of physical, mental health and intellectual disability (Elman, 2005).

Another recent study echoed Brownridge's conclusions, finding a high rate of sexual assault amongst women with disabilities (Martin et al., 2006). This study, too, found that there was a considerable discrepancy between the rates of physical violence, which were not significantly more than for women without disabilities, and the rate of sexual assault, which was 4 times the rate of other women. It found that young and non-white women, unmarried women and employed women were more likely to be assaulted.

The sexual abuse of women with psychiatric disorders or intellectual impairment, however, is not just perpetrated by carers or other residents in care homes or institutions. It can take the form of sexual exploitation in the prostitution industry. The feminist movement has been split in recent years between those who see prostitution as violence against women (Barry, 1995; Jeffreys, 1997; Stark & Whisnant, 2004), and those who use the language of neo-liberalism to normalise that form of men's behaviour by defining prostitution as 'sex work', speaking of women's choice and agency in entering prostitution, and describing prostituted women as entrepreneurs (Pattaniak, 2002; Lisborg, 2002). My perspective is that prostitution is harmful to all women. But prostitution depends upon the exploitation of the most vulnerable and marginalized of women, indigenous women, trafficked women, as the business can find it difficult to attract women who have other opportunities to earn a living. As a result, women with mental health problems and intellectual impairment are vulnerable to exploitation in the industry.

The prostitution of women with disabilities

In legalised prostitution systems, such as those in most states of Australia, women with psychiatric disorders or intellectual disabilities are exploited in brothel prostitution. In Australia the legal brothel and strip club industry was worth 2 billion Australian dollars in 2006 according to an industry report (IBIS World, 2007, p. 4), though the illegal industry, much of it in the grip of organised crime, still makes up around 80% of the industry (Sullivan, 2007, p. 202). There is no evidence to suggest that women with disabilities are being deliberately employed in prostitution but there are indications that women suffering intellectual impairment are particularly vulnerable to being exploited in the industry. Prostitution may offer the only form of 'work' that a woman with a disability is able to access, especially if a woman is subject to periods of psychological wellness and periods of illness and unable to hold down regular

employment. Women with intellectual disabilities may be particularly susceptible to the inducements of pimps and easily manipulated in prostitution.

Sexual exploitation of women with disabilities is not necessarily understood to be a problem in relation to the legal industry. Under the Australian state of Queensland's criminal code, however, it is an offence to have carnal knowledge of someone who is defined as having an 'intellectual impairment' (Carrick, 2006). Participants in a discussion about the issue of prostitution and disability on Australia's National Radio (see Carrick, 2006) argued that this was an abuse of the rights of people with disabilities. The prohibition on women with intellectual disabilities being exploited in brothel prostitution was unfair, Delaney and Candy, from SSPAN, Sexual Service Providers Advocacy Network, considered. When asked whether a woman with the mental age of 10 should be allowed to work in a brothel, however, Delaney said she thought not. But the SSPAN spokeswomen pointed out that the prohibition also potentially prohibited women suffering mental illness from being prostituted in brothels. Someone with bipolar disorder, for instance, 'who may get psychotic from time to time, somebody with severe depression, who may be good for some periods, not so good at other periods, who may be stabilised on medication' (Carrick, 2006). This raises the question of whether prostitution is a good work choice for women suffering depression when the rates of depression in prostituted women or those who have managed to leave prostitution are so high, and many other mental health conditions such as post-traumatic stress disorder have been identified in prostituted women (Farley, 2003).

Evidence about the exploitation of girls and women with disabilities in prostitution is anecdotal at present. No research has been conducted into the percentage of prostituted women who fall into this category. But the anecdotal evidence suggests that girls with disabilities are being prostituted. In April 2007 a convicted double police murderer named Bandali Debs appeared before a court in Melbourne charged with the murder of an 'intellectually disabled teenager' whom he shot after 'having sex' with her (Jenkins, 2007, p. 5). Kristy Mary Harty's body was found in undergrowth in the bush and she is described as having been 'working as a masseuse and was prostituting herself to drivers at Dandenong the day she died' (Jenkins, 2007, p. 5). Evidence of such exploitation is only available when media reports of court cases related to prostitution choose to mention the disability, as in a case from New Zealand, which decriminalised prostitution in 2003. In 2005 a male illegal brothel owner was prosecuted for employing two underage prostituted girls in a brothel, supplying drugs, and paying for sex with a minor. The 14 year old girl is described as being drug addicted and the 16 year old as having 'severe learning difficulties' (Henzell, 2005, p. 3). The offence was underage prostitution since there is nothing in the New Zealand legislation to prohibit the prostitution of those with intellectual disabilities.

When women with disabilities are used in the prostitution industry in Australia this is incidental and the disabilities are not highlighted so as to appeal to disability fetishists. Male disability fetishists, however, do deliberately target women with disabilities. In the age of the Internet, the male sexual interest of fetishising disabilities in women has expanded and been normalised by websites offering pornography and services such as the ordering of mail order amputee brides.

Disability fetishism

All manner of women's disabilities are offered to 'devotees' on sites such as ampulove. The range of pornography on offer demonstrates that there are men who get sexually excited about everything from braces on teeth and braces on legs to amputation (Elman, 1997). Amputation is the most common interest and offers three sub-specialisations. Devotees are those men who get sexual satisfaction from women's disability, particularly limb amputation. Pretenders are those who pretend to be amputees or disabled themselves by tying one leg up behind them or using wheelchairs. Wannabes are those who seek actual amputations, preferably in hospitals and through public health services. The latter two categories, though overwhelmingly male, may include some women. The male behaviour of disability fetishism originates in the construction of male sexuality to eroticise power difference. Men's expectation that they may pursue, approach and stalk women with disabilities, make them into pornography and sexually exploit them in prostitution and as mail order brides, is an aspect of the male sex right.

It is the devotees that create the most difficulties for women with disabilities. They may harass amputee women in the street, join organisations and attend conferences that support amputees in order to derive sexual satisfaction from seeing stumps and getting close to them, or even become prosthetists. Material from the Amputee Coalition of America shows how this latter form of sexual abuse works. According to the ACA, women amputees are harassed on the Amputee Web Site, which is a facility set up to serve amputees. They are stalked by 'devotees' (Amputee-online, n.d.). The result is that 'Many amputees fear revealing the fact that they are amputees in case a devotee without moral fibre sexually harasses them via e-mail' (Amputee-online, n.d.). They are advised, 'if a person starts asking you various questions about crutches, clothing, do you go to bars, shoes and other habits, BE SUSPICIOUS!' (Amputee-online, n.d.).

The website held a debate on the issue of devotees. Members of ACA wrote about their response to devotee interest in female amputees in the organisation. Gracie Rossenberger, board member of ACA, when asked what her concerns were about devotees, responded, 'These are individuals who are enamoured with the maimed bodies of human beings. They repulse me' (Amputee-online, 2000). She worries that the presence of devotees will keep members away from the ACA. They should not have to 'work up the courage to come to a meeting' and have to worry about 'unaccompanied women … walking to their room unescorted, going to the pool and having deviants take their pictures' (Amputee-online, 2000). She is concerned as more and more children become involved in the organisation that devotees will attempt to 'interact with the children'. She worries that they get into 'professional positions' where they can 'use us to feed their fascination on a daily basis' and does not want to have to 'question and squirm every time a prosthetist touches me because I don't know if he is or isn't a devotee'. She asks, 'How safe can we feel standing there partially dressed, totally vulnerable and exposed wondering if there is a hidden camera taking our picture that will end up in next month's "new attractions" on the internet. There are so many women whose pictures have been taken without their awareness that are

now being viewed and used for fantasies by this population and we have no way to stop this hideous invasion of our privacy' (Amputee-online, 2000).

In the same discussion Carol Wallace wrote 'Attending conferences these days feels like being in a "meat market" as they hang around the sidelines hoping to catch a "glimpse" of our stumps' (Amputee-online, 2000). Some women, she says, 'unknowingly wear clothing that exposes their stumps' which provides the 'turn on they are looking for' to the point of excess. As she reports, '"Over-stimulated to the point of emotional shutdown" is how one devotee so aptly described his experience of seeing so many of us in one place. How nice to know our loss is someone else's "overload"'. She asks 'What level of trust can you have in a man who might leave you for a "prettier" stump?' (Amputee-online, 2000). She explains the involvement of some amputee women in the creation of pornography for devotees by the fact that they have 'no other way to earn a living and there is big money in the selling of pictures'. There is even trafficking in amputated women, she states, 'Foreign women are a target of devotees, who bring them to the United States and set them up as prostitutes for their population to use. For many of these women their new lifestyle is a step above the way they were living before coming here' (Amputee-online, 2000). Men's amputee fetishism is, thus, a source of harassment and distress to women amputees. The infiltration of fetishists into amputee networks makes places of potential safety and support into places of danger.

The sexual interest that devotees have in women with disabilities is, in some cases, transferred onto their own bodies with the result that they become 'pretenders' or 'wannabes'. 'Pretenders' go around in wheelchairs or with one leg constantly bent upwards simulating disability, whereas 'wannabes' seek to have limbs amputated. The desire to have limbs amputated is overwhelmingly a male preoccupation. Recently, 'wannabes' have created a political movement to demand toleration, and limb amputation on the public health service (British Broadcasting Corporation, 2000; Furth & Smith, 2002; Elliott, 2003). The desire for limb amputation is called body identity integrity disorder (BIID) by those campaigning for recognition (First, 2004). As several commentators have pointed out, it is similar to transgenderism (Jeffreys, 2005, in press-b). One similarity is the fact that both interests of men appear to be sexually motivated and forms of masochism (Lawrence, 2006). In both cases the fetishists themselves proclaim that their disorder has nothing to do with sex, but is rather an issue of 'identity', which can only be resolved through surgical removal of healthy limbs or sexual characteristics i.e. legs or penises.

Both psychiatrists, such as Michael First, and wannabes, such as Greg Furth, are involved in discussions as to whether BIID should be included in the Diagnostic and Statistical Manual, the US encyclopedia of psychiatric conditions which is edited by First (Furth & Smith, 2002). Such an inclusion would enable limb amputation to be recognised as a form of therapy and mean that it could be performed with public health service funding. In the context of the serious obstacles that people with disabilities have to overcome in their lives in order to find love and sexual pleasure, it might be hard to establish full sympathy with a population of largely male disability fetishists which is seeking state support to become amputees for sexual purposes. The fact that this proposal receives any support reflects the importance attached in male dominant societies to men's desires, however unreasonable.

Men's sexual desires, which are developed out of their unequal power relations with women, are regarded as legitimate and accommodated by male dominant states with the provision of legalised or tolerated prostitution and pornography industries. Men's problematic sexual behaviour in buying access to women and girls causes serious mental and physical harms to the women involved (Jeffreys, 2004; Farley, 2003), as well as social harms such as organised crime, destruction of relationships and of social amenity (Sullivan, 2007). One unfortunate result of the normalisation of this industry is that disability organisations and activists, such as Disability Now in the UK, seek access to the same masculine privilege that other men possess, of sexually exploiting women in prostitution (Disability Now, 2005). The legalised industry in Australia markets prostitution to organisations for people with disabilities, their carers and men with disabilities as a way to 'educate' men with disabilities sexually, enable them to realize their sexual rights, or reduce their aggression.

Prostitution and the sexual 'needs' of men with disabilities

Disability is an important niche for expansion by prostitution industries. The sexual rights of the disabled are employed as a way to make prostitution respectable and to suggest that it serves a noble purpose. Thus the sex industry lobby group, Sexual Freedom Coalition, in the UK, staged a demonstration of disabled men against proposed legislation that would have restricted men's rights to access prostituted women in February 2008 (Sexual Freedom Coalition, 2008). A 2008 documentary, aired on Channel 4 in the UK and SBS in Australia, is described in an Australian newspaper review as a 'charming documentary on the sexuality of disabled people'. A disabled man who was taken on a trip to Spain by his parents to access prostituted women in a special brothel for 'people with various disabilities' is filmed making a return trip with two other disabled men (Schwartz, 2008).

This normalisation of prostitution in the interests of servicing disabled men's 'sexual rights' is supported by the rhetoric about the sexual rights of people with disabilities that is common to much academic and practitioner literature on disability (Earle, 2001). Much of the material on sexuality and disability is composed of reasonable arguments for information and training to be supplied to persons with disabilities so that they may understand sexuality, pleasure themselves, develop relationships, and, in the case of men and boys, learn not to engage in unacceptable behaviours such as masturbation in public. But the sexual rights argument goes further and leads to demands that men with disabilities, though gender is never referred to in this literature which is carefully neutral, should not only be able to access pornography and prostitution, but be helped by their carers, including nurses, to do so. The argument has gone so far, under the title of 'facilitated sexuality', that it appears that nurses may be expected to become adjuncts to the sex industry or even a part of it, by directly 'sexually facilitating' men with disabilities themselves (Earl, 2001).

Manifestos of sexual rights have come from several quarters onto the international stage and into human rights discussions in the decades since the sexual revolution. The

manifestos are gender neutral, which is problematic when, under male dominance, male and female sexuality are constructed in such different ways. As Jennifer Oriel (2005) has pointed out in her study of the implications of sexual rights arguments for women, not only is sexuality constructed around the male sex right, with its assumed right to access women, but sexual pleasure for men is often specifically constructed out of the subordination of women, through rape, pornography and prostitution. Thus any concept of women's sexual rights must be based upon recognition of the inequality of men and women, of women's vulnerability, and specific understanding of women's right to bodily integrity and not to be sexually exploited. Based on this understanding, the United Nations Convention on Disability, which came into force in 2008, usefully states that 'Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others' (United Nations, 2008: Article 17). A gender neutral concept of sexual rights, on the other hand, leads directly to the idea that men with disabilities should be able to abuse women in prostitution in the same way as men without disabilities do, despite the fact that rights should be positive in their effects and not bring harm through the infliction of a 'right' upon another.

The normalisation of sexual exploitation in relation to men with disabilities is revealed in a 2005 survey by the UK organisation, Disability Now (Disability Now, 2005). This revealed the importance of disaggregating the interests of women from those of men since the survey found that it was men with disabilities that were using and wished to use prostituted women. It found that just over one-fifth of men with disabilities in the UK (22.6%) have used sexual services, despite the fact that brothel prostitution is illegal. This figure is double the national male average of 11%. The male respondents would almost all consider doing so if there was a legal, regulated service. The figures were rather different for women, with less than 1% of women having used 'sexual services', although 16.5% had considered it and 19.2% would think about using a legal, regulated service. Disability Now used the survey in support of its call for prostitution in the UK to be legalised. Pornography, too, is argued by some disability rights advocates to be vitally necessary to the sexual rights of the disabled. Thus Tim Noonan, in an article on 'Netporn and the Politics of Disability' states that, 'access to online porn resources is even more crucial and significant for people with disability, often being THE ONLY — rather than ONE of SEVERAL options for consumption and participation' (Noonan, n.d.).

In the state of Victoria in which I live, which has legalised brothel prostitution, brothels specialise in offering 'services' to people with disabilities (Sullivan, 2007). This is a money spinner for the prostitution industry. Also, by promoting itself as offering education and needed sexual relief to people with disabilities, the industry normalises itself and improves its image. Sexpo, the trade show of the prostitution and pornography industry which is held in state capitals all over Australia to promote prostitution, has a section of the display area dedicated to charities for people with disabilities, such as the Muscular Dystrophy Association, and advertises itself as educating people for sex and lifestyles. The cause of ensuring men with disabilities access to prostitution is well advanced in Australia. In Victoria service providers have an obligation to support the sexual lifestyles of 'people' with disabilities and this obligation may include access to prostitution (Sullivan, 2007: 176). Two Australian organisations exist that are dedicated to enabling men with disabilities to gain access to prostitution. One, Accsex/Access Plus, receives Federal Health Department funding. Another is Touching Base which was created in New South Wales through the support of the prostitution industry in that state and People With Disabilities to 'facilitate the links between people with a disability, their support organisations and the Sex Industry' (Touching Base, n.d.). Mainstream health and disability organisations support Touching Base, such as Family Planning Association NSW and The Spastic Centre of NSW. It offers 'professional development' to prostituted women through training them to work with men with disabilities, and promotes prostituted women as 'sex therapists' who can offer specialised services to people with disabilities such as teaching men with intellectual disabilities how to do sex. It advises that disability service providers should institute Sexuality Lifestyle Assistants to provide transport, positioning and other services that will enable men with disabilities to prostitute women.

Touching Base sees residential aged care as another potential niche market for the prostitution industry. According to an article on their website, aged care services arrange for their male clients to access prostituted women. As a 'lifestyle coordinator' in nursing homes commented, carers provide sexual intimacy to elderly men, 'If male patients are fit enough, some homes send them to brothels' (Gray, 2005). A spokesperson for the Daily Planet brothel, commented, 'It happens all the time. Several of our girls have nursing backgrounds and often still work in aged care… Some homes send men in small groups, so they can chat about it all afterwards, just like the boys…If people are treated with dignity, they feel dignified' (Gray, 2005). The Touching Base website features a discussion on the question, 'How does the right that individual sex worker's (sic) have to decline a client, sit with the right of people with disability to access commercial sexual services without experiencing discrimination on the basis of their disability?'. George Taleporos wonders whether brothel managers would find themselves in breach of the Disability Discrimination Act if they failed to provide access to a prostituted woman. Being refused access would, Taleporos considers, 'have a devastating effect on that person's self esteem' (Touching Base, n.d.). The fact that such a question can be raised suggests that legalised prostitution educates men in the idea that women are products to be used rather than as persons with a right not to be sexually exploited.

Prostitution is posited as a way that men with intellectual disabilities could be dissuaded from sexually assaulting other persons with intellectual disabilities. This form of sexual assault, predominantly in institutions, and in many cases consisting of repeated abuse of the same victim, is emerging as a worrying issue (Bazzo, Nota, Soresi, Ferrar & Minnes, 2007). Thus Anthony Walsh from Family Planning in the Australian state of Queensland says that 'our experience at Family Planning Queensland, suggests that many men with significant intellectual disabilities, are perpetrating sexual offences' (Carrick, 2006). The answer, he considers, is 'sexuality education and appropriate support' which could help in 'decreasing the risk of sexual assault against vulnerable people in our society' (Carrick, 2006). The worrying possibility is that service providers might

consider prostituted women as the appropriate deliverers of this form of 'education', especially when brothels set themselves up as specialists in the field and specially train their workers, as is happening in legalised brothel prostitution in Australia.

The sexual use of prostituted women, who are paid to dissociate emotionally whilst their bodies are entered, is not an appropriate means of sex education, or of reducing men's sexual violence. Rather than teaching boys and men with disabilities about mutual sex, respect for the personhood of women, relationships and intimacy, prostitution teaches the exact opposite. The other implication here is that if men with disabilities are not given access to prostituted women into whom to ejaculate, they may attack others, as if there were a biological sexual drive which, if not satisfied, would naturally lead men to such violence. Prostituted women are already being used as a means to calm down sexually aggressive men with disabilities in Australia, as the stories about clients on the Touching Base website make clear. 'Andy' engaged in problematic behaviour such as stealing women's clothing. He was supported in forming the idea that he wanted to access prostituted women, despite cultural inhibitions that he experienced towards this idea. He began, and continued, to visit prostituted women though he could not remember the visits (Touching Base, n.d.). 'Bill' was violent and aggressive and sexually harassed his carers after an accident affected his speech and the left side of his body. The visit to a prostituted woman that his carers arranged was unsatisfactory because he experienced premature ejaculation. His aggressive behaviour continued (Touching Base, n.d.). The idea that the prostitution of some women will lead to a reduced rate of sexual aggression towards others, the catharsis argument, is a myth which feminists have long sought to dispel in relation to men without disabilities, so it would be hard to see why it should deserve a revived currency in relation to disability (Jeffreys, 1997). Some of those writing in the field of disability studies express the forms of sex education that boys with intellectual disabilities need in ways that would preclude sexual exploitation such as, 'how to express positive attitudes towards their sexuality and their body, share rules promoting self-respect and respect of others, enjoy the greatest degree of autonomy possible, live with one's sexuality within satisfying social relationships, adequately practise safe sexual acts and defend themselves from possible aggressors' (Bazzo et al., 2007, p. 111). This approach is more likely to be effective in changing sexually exploitative behaviour than the provision of prostituted girls and women, some of whom, after all, may themselves have disabililties.

In countries where prostitution is not legalised and 'sex therapy' cannot be offered in brothels, such as the USA, men with disabilities may have to make do with 'sex surrogates' who can only be obtained through a regular therapist. Sex surrogates are paid, as in prostitution, but are promoted as subtly different. They are recommended in some disability studies literature (see Aloni & Katz, 2003). In one article by a man with a disability who decided to access a 'sex surrogate' for his first sexual experience, the 'services' offered sound remarkably identical to those of prostitution. Mark O'Brien, who is paraplegic, wanted to be 'held, caressed and valued' (O'Brien, 1990). But, unfortunately, he was unable to find anyone to have a loving relationship with him. Surrogacy/prostitution was his recourse. The 'surrogate' undressed him, after his carer delivered him to a friend's home for the experience, and then sucked his penis, instructed him to kiss her breasts and on the second visit managed to get his erect penis into her vagina. There was no 'therapy', just the usual practices of prostitution.

The supposed differences between prostitution and surrogacy are detailed in a document from 'The Sex Institute' in New York (Noonan, 2002). Sex surrogates provide 'sex therapy' we are told, and are 'mostly female working with heterosexual males'. The difference lies in intent. Thus 'the prostitute's intent' was to immediately 'gratify localised on genital pleasure' whereas the surrogate's intent was 'long-term therapeutic re-education and re-orientation of inadequate capabilities of functioning or relating sexually' (Noonan, 2002: 3). There has to be a 'supervising therapist' and the 'usual therapeutic approach is slow and thorough…Exercises are graduated and concentrate on body awareness, relaxation and sensual/sexual experiences that are primarily non-genital.' (Noonan, 2002: 3). Where appropriate, the surrogate also teaches 'vital social skills and traditional courtship patterns which finally include sexual interaction.' (Noonan, 2002: 3) None of this happened with Mark O'Brien above, who seems to have got old-fashioned prostitution instead.

Men with disabilities are likely to have difficulties accessing the exploitation of women in pornography and prostitution because of mobility issues or intellectual disabilities. In male dominant cultures where these forms of abuse of women are considered an ordinary expression of men's sexuality the argument has arisen that it is just and fair for the carers of such men, including nurses, to enable this access and thus ensure that men with disabilities have their 'rights'. This is called 'facilitated sex'. This concept creates a conflict of interest between such men with disabilities and their largely female carers, who may have very good reasons for not wanting to supply pornography, help their patients to masturbate, deliver them to brothels or help to position them for sexual intercourse. The carers are likely to be poor migrant women who will be in no position to defend themselves against demands by their clients for such services (Lyon, 2006). This conflict is not necessarily well recognised in the literature. Thus Sarah Earle, a UK nursing studies academic, criticises the 'overriding concern with risk and prevention of sexual abuse and exploitation, to the cost of patients' sexual needs' in literature on sex and disability (Earle, 2001: 434). Earle is not sympathetic to the fact that carers, or personal assistants, may be unenthusiastic about recognising the 'sexual needs' of men with disabilities, and tend to see their clients as expressing 'wants' rather than 'needs' (Earle, 1999). An article in *Learning Disability Practice*, gives an indication of the kind of sexual harassment carers experience in one UK setting. The article explains that 'sexual harassment by service users is seen as "part of the job" in many day centres' (Parkes, 2006: 35). One focus group participant 'described how a male service user targeted her sexually. "He just became completely obsessed…bit like a love/hate thing, you know what I mean, sort of very…er masturbating, you know what I mean? It was quite stressful"' (Parkes, 2006: 35).

The discussion of facilitated sex in the UK takes place in a context in which local government funding is 'available to disabled people as direct payments for personal assistance'

(Earle, 2001: 436). Earle defines 'facilitated sex' as 'ranging from the provision of accessible information and advice to the organisation of sexual surrogacy' (Earle, 2001: 437). It might, she says, include assistance to 'negotiate the price when using the services of a prostitute' (Earle, 2001: 437). More specifically, a person might be required to 'facilitate sexual intercourse between two or more individuals, to undress them for such a purpose, or to masturbate them when no other form of sexual relief is available' (Earle, 2001: 437). Earle uses gender neutral language and may be thinking of female nurses masturbating men with disabilities, a form of unwanted and potentially highly distasteful activity but one within the ordinary expectations in male dominated societies that women should be accessible to men and sexually service them. She does not comment on whether female nurses would be expected to masturbate women with disabilities, or whether male nurses would be expected to do so, or whether women with disabilities would want any of this kind of contact. She does not comment on whether male nurses would wish to masturbate men with disabilities, or whether there would be any demand for such a service. One problem here is that male carers might be able to use the justification of facilitated sex for sexually abusing women in their care. The major problem is that expecting carers to sexually service men is just another form of sexual exploitation. As women in many occupations are developing sexual harassment codes and understandings that they do not, as employees, have to sexually service their bosses, fellow workers, or clients, it seems that some disability rights advocates may be seeking to sexualise nursing and caring in ways that are in direct contradiction to this progress.

Earle (2001: 438) explains that 'for some disabled people, facilitated sex is qualitatively no different to other forms of assistance, such as help with washing, dressing and elimination needs' and suggests that if 'the nursing profession was able to appreciate this lack of distinction, it might be possible for facilitated sex to play a greater role within the provision of holistic care' (Earle, 2001: 438). The provision of 'facilitated sex' such as masturbating men with disabilities will enrich the role of the nurse, Earle argues, by offering nurses 'an opportunity to develop their skills in nursing the whole person. Furthermore, the inclusion of sexuality within a holistic framework would be intellectually and emotionally rewarding and would 'add value' to the role of the nurse' (Earle, 2001: 439).

In the last half of the 19th century, Florence Nightingale, recognised as the founder of the nursing profession, worked to relieve nursing of the stigma of prostitution so that it could become respected (Woodham-Smith, 1950). Nursing was associated with prostitution because nurses touched men's naked bodies and respectable women were not supposed to do such a thing. Nursing did become a respected profession, but in the twenty first century sexual rights campaigners look set, if they are successful, to make prostitution part of a nurse's job and undo all that good work.

There is a fundamental contradiction involved in the way that disability politics approaches sexual exploitation. Rhetoric about sexual rights which gives men with disabilities the right to prostitute women, and even to demand sexual servicing from carers and nurses, is contradicted by the need to free women with disabilities from sexual exploitation. Prostitution and 'facilitated sex' teach a depersonalised, objectifying form of sexuality to men with disabilities which requires that a woman suffers emotional and/or physical abuse. The issue of the sexual demands that are made of personal carers is an area that is greatly in need of feminist research, to discover how women who are often vulnerable by virtue of financial desperation or even debt bondage, language problems and illegal status are dealing with the expectation, in some cases, that they are available to be prostituted. The discussion of disability and sexuality needs to incorporate feminist understandings of what constitutes sexual exploitation and, where appropriate, disaggregate the interests of women with disabilities from those of men with disabilities.

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