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Sexuality, Sex Positivity, and Disability: A Brief Narrative Analysis of Marginalization, Intersectionality, and Professional Practice

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Abstract: This article presents a brief narrative analysis of the sexual rights of persons with disabilities, framing sexuality as an essential human right that has been systematically suppressed by the hegemony of the medical model of disability. The primary objective is to deconstruct the historical, biopolitical, and structural barriers that impede sex positivity for this population while advocating for a paradigm shift toward disability-affirming and trauma-informed clinical practices. By weaving together the theoretical "Silenced Fairytale" narrative with lived-experience vignettes, including the experiences of self-advocates such as Denise Sherer and Pauline, this analysis illustrates the profound human impact of institutional surveillance and systemic marginalization. The discussion highlights a persistent societal paradox where disabled individuals are simultaneously infantilized as eternal children and pathologized as hyper-sexual threats. Furthermore, the article explores the messy intersections of LGBTQIA+ identity and disability, examining how diagnostic labels often silence internal gender and sexual realities. Ultimately, this work provides practitioners with a narrative guide for deep self-reflection, transforming traditional clinical directives into a contemplative intervention. By acknowledging that disabled people themselves are the primary experts on their own realities, practitioners can move beyond the "dis-" prefix of perceived brokenness to support the flourishing ability of the whole person. This analysis concludes that sex positivity is not merely a social preference but a non-negotiable human right that must be extended to all bodies, regardless of cognitive or physical difference. Especially in the midst of a shifting political landscape heavily influenced by the ongoing COVID-19 pandemic, it is more important than ever for practitioners to understand and advocate for disabled autonomy in not only sexuality, but all aspects of their lives.

Keywords: LGBTQIA+, Intersectionality, Eugenics, Marginalization, Ableism

INTRODUCTION: THE SILENCED FAIRYTALE

Once upon a time there were two women who, due to circumstances out of their control, began living together as roommates. They did everything together: they shared a home, they shared meals, they even worked together at the same job, passing time at the workshop with conversation and laughter. Time went on as it often does, and these two women found themselves becoming good friends, and maybe even more. Soon they began holding hands and eventually, they shared in true love's first kiss.

In a traditional fairytale, this would be the prelude to a "happily ever after." However, as chronicled in Michael Gill's Already Doing It (2015), the reality for these women was no modern lesbian fairytale: instead of a budding romance, they were faced with institutional surveillance and control. Because they were labeled with intellectual disabilities and lived within a supported arrangement, their private intimacy was

pathologized by care staff and family as inappropriate. They were subsequently separated at both home and work, their relationship dismantled by an external authority that viewed their agency as a clinical deviance rather than a bid for authentic human connection.

This vignette serves as a stark entry point for understanding a broader systemic failure. As disabled activist Barbara Waxman-Fiddicuia (1994) observed, no other group faces the specific level of sexual and reproductive restriction that the disabled community does, ranging from the prevention of marriage to the active denial of sexual literature and education. This suppression occurs despite the World Health Organization's (WHO, 2009) explicit mandate that sexuality is an essential human right, and the 2007 Convention on the Rights of Persons with Disabilities (CRPD), which codified the rights of disabled persons to intimate relationships.

The physical danger of this systemic erasure is perhaps most poignantly illustrated in the documentary Crip Camp through the experience of disability scholar and self-advocate Denise Sherer. (This film is highly recommended for more insight into sexuality for people with disabilities and the disability rights movement). Sherer, who has cerebral palsy which impacts her mobility and speech, shares a story about "not wanting to die a virgin" and entering a sexual relationship with her bus driver. Soon after, she finds herself in the emergency room with severe abdominal pain. The doctors decide that she must have a burst appendix and operate, removing a completely healthy organ. After undergoing an unnecessary surgery to remove her totally healthy organ, the film reveals that Denise actually has gonorrhea. Looking down the lens of the camera, Denise explains that the doctors took one glance at her and never even considered that she would be sexually active because, in her own words, "who would want to fuck with me" (Newnham & LeBrecht, 2020). This medical negligence demonstrates that the refusal to acknowledge disabled sexuality is a direct threat to medical safety; the doctors looked at Sherer and, blinded by the medical model, assumed she was a non-sexual object and violated her bodily integrity through unnecessary surgery. When medical professionals ignore the sexual agency of patients, they risk committing medical errors with devastating consequences, and reinforce a hierarchy of desirability that forces disabled individuals to internalize their own exclusion. Sherer's heartbreaking reflection on her desirability reveals the devastating impact of that internalization.

HISTORICAL CONTEXT: FROM SIDESHOWS TO SYSTEMIC SUPPRESSION

The history of disabled sexuality is a narrative of erasure and biopolitical control. In the early 20th century, individuals with visible disabilities were often exploited in "freakshows," where they were paraded as "eternal children," a trope that stripped them of adult agency and sexual identity (Hunter, 2005). Then, during the industrial revolution, knowledge in learning and development began increasing. This resulted in an expanded definition of who was considered educable, which increased educational institutionalization (Brown & Radford, 2015). While the original intention may have been born from a noble desire to educate, these institutions became sites of intense surveillance where sexual agency was treated as a management problem rather than a developmental right.

This interest in containing and educating disabled people began to intertwine with the eugenics movement in the early 1900s, creating a psychological paradox that still haunts current professional practice. On one hand, eugenicists hyper-sexualized disabled people,

framing them as "inevitably criminal" and "promiscuous" to justify a century of forced sterilization and castration (Kempton & Kahn, 1991). On the other hand, the general public viewed those living at home as asexual, innocent children (Collier, 2017). The tension within this juxtaposition, that is, simultaneously being a sexual deviant in the eyes of the state and an asexual infant in the eyes of the family, has served to justify the systematic suppression of sexual rights for people with disabilities to this day.

Following World War II, public knowledge of the horrors of nazi eugenics led to a slow decline in sterilization and the beginning of deinstitutionalization (Reilly, 2015). The Sexual Revolution of the 1960s and 70s eventually provided more unrestricted educational materials, though it took until the 2007 Convention on the Rights of Persons with Disabilities (CRPD) for the international community to formally acknowledge the right of disabled individuals to maintain intimate relationships. Since then, sex positivity has finally begun to make its way into the disability field, and since platforms like Tiktok have gained notoriety, disabled creators have amassed large followings where they are able to talk candidly about their sexuality, sexual experiences, and the sexual discrimination they face (Lawson, 2021). Some countries with legalized sex work even have programs dedicated to providing safe facilitated sexual experiences for people with disabilities who express that desire at little or no cost (McGrath, 2016). While this progress is promising, the structural barriers from a lengthy history steeped in a global culture of eugenics still remain.

ANALYSIS OF SOCIETAL AND STRUCTURAL BARRIERS

One of the most significant structural barriers that people with disabilities face around understanding their own sexuality comes from a lack of appropriate sexual education. In public schools, students with disabilities are often kept entirely out of sexual education classes, even if they are otherwise included in Health/PE with their peers. For example, Frawley and Wilson (2016) conducted a focus group of teens and young adults with intellectual disabilities, and when they were asked if their schools did a good job teaching them about sexual education the overwhelming response was laughter followed by a resounding no, with one participant elaborating, “...except for the mainstream classes, they give you heaps of information then.” This response illustrates that even for those people with disabilities who were able to attend the typical public school sexual education courses, the curriculum is often not modified or adapted for diverse learners.

Even education programs that are specifically designed for people with disabilities do very little to promote a positive sexual identity for their learners. Instead, most approach this education from a harm reduction perspective, focusing on sexual assault and abuse prevention rather than promoting safe and healthy sexual lives (Gill, 2009). Research shows that appropriate sexual education leads to better outcomes and less potential for abuse for this population (Bourke et al., 2014; Lindberg & Maddow-Zimet, 2012). So why are people with disabilities continuously denied appropriate sexual education? The reason proposed here is two-fold, containing opposing misconceptions.

The marginalization of disabled sexuality is maintained through the persistent dichotomy of infantilization and hyper-sexualization. Many caregivers and practitioners view disabled adults as "eternal babies," a perspective that leads to a profound exclusion from sexual health education (Collier, 2017). Despite the fact that people with disabilities often still go through puberty at rates similar to their nondisabled peers, parents will claim that

their child has no interest in sex or relationships. Some of these parents go so far as to suggest genital mutilation or forced sterilization if the disabled pubescent child or young adult does become aroused (Hingsburger & Tough, 2002), which is still legal in many parts of the world (European Disability Forum, 2022; National Women's Law Center, 2022). This infantilization is illustrated in the story of Kailani, a former special education student interviewed for this project. Kai was a typical presence in her school; she had strong social skills, many friends with and without disabilities, and was a fantastic softball player. By her senior year, she was included with her nondisabled peers for all elective courses, many extra-curricular activities, and even a portion of her academic courses. Yet, she was pointedly removed from those peers during the sexual education portion of her health class. When asked about it in the interview, Kai recalled the confrontation with her family:

> *And I even asked my parents one day about it, like, hey! Why [do] my friends have this class? We're in the same grade! Why am I not taking this class?!...I think they just felt like that wasn't going to be part of my life growing up…they probably didn't think I would be on my own. They probably thought I would live with them for the rest of my life. That's just the bottom line.*

She went on in the interview to talk about how, because of her parents' outright refusal, most of the knowledge she had about sexuality she obtained through talking to her friends or boyfriends at school, or learned later on in adulthood. She now works several jobs and lives on her own with her partner, but not before her parents' overprotection led to significant consequences. As a direct result of her lack of sexual education, Kai entered adulthood with fragmented knowledge, leading her into several abusive relationships before she could establish a healthy partnership. This is the reality of many in the disabled community: no formal education, partial sexual knowledge pieced together secondhand from peers, and a significantly increased risk for abuse. Stories like Kai's are corroborated by research on lowered expectations and overprotection of people with disabilities (Sanders, 2006), as well as the devastating consequences that can result from a lack of proper sexual education (Baladerian et al, 2013; Treacy et al., 2017).

Conversely, when disabled individuals express sexual interest, they are often labeled as having uncontrollable urges or being hypersexual (Ailey et al., 2003). Historical academic rhetoric suggested that even teaching autistic individuals about basic sexual functions like masturbation would lead to moral deterioration and criminal behavior (Elgar, 1985). These misconceptions are reinforced by legal and policy-based hurdles. For instance, until 2017, Irish law criminalized sex for people with intellectual disabilities unless they were married, based on the assumption that they lacked the capacity for consent (Kelly et al, 2009). This law was only overturned after intense pressure from disabled self-advocates, such as those highlighted in Anna Rodgers' film *Somebody to Love*, who demanded recognition as equal sexual citizens (Ryan, 2016).

For folks with intersecting marginalized identities alongside their disability, these societal and structural barriers are often amplified (Artiles, 2013). Intersectionality for people with disabilities can be messy, particularly for those who identify as queer or a member of the LGBTQIA+ community. Research indicates that while gender nonconformity may be more prevalent among certain populations, such as those with autism (Warner et al., 2026), a staggering 74% of people with intellectual and developmental disabilities have no access to LGBTQIA+ knowledge (Chacra et al., 2017). This lack of language and education around sexuality and gender often forces individuals to repress their true identities.

Self-advocate Pauline's narrative provides a vital case study of this struggle. Labeled as a boy with "slight mental retardation" (common terminology at the time) in her childhood, Pauline was questioning her gender by age five or six. However, the diagnostic labels imposed upon her acted as a silencing mechanism. Pauline's experience of double marginalization was profound: disability support groups were often uncomfortable with her trans identity, while LGBTQIA+ groups were unequipped to accommodate her disability. In response, she founded The Rainbow Group to create a space for self-advocates who exist at this intersection. Her mantra, "Nothing about us without us," serves as a directive for both curriculum development and clinical practice; in fact, Pauline has been an instrumental collaborator in helping to cultivate and provide sexual education for and by folks with intellectual and developmental disabilities (Bosma, 2021). Practitioners must recognize that clients like Pauline contain multitudes; they are not merely their diagnosis. Clinicians and educators must avoid the reductionist trap of viewing disability as the most important factor in a person's life, especially when they are navigating the evolution of a sexual or gender identity that was previously denied them.

IMPLICATIONS FOR PRACTITIONERS

To provide affirming care and sexual education, practitioners in both the medical and educational fields must first confront the ableist etymology of disability itself. The very word has an inarguably negative connotation. The root word is *ability*, which can be defined in a few ways, including the means or *skill to do something* or a *proficiency* in a particular area. The prefix dis-, however, means *no*. In the very etymology of the word, disability means *no ability, no proficiency, no skill* in *anything*. This concept, that people with disabilities are incapable or unable, permeates every facet of society, including among educational and clinical practitioners. This often leads to a psychological counter-transference, where practitioners subconsciously view the disabled client or student as broken and needing to be fixed without considering the perspective of the disabled person themselves. True intervention begins when practitioners understand that they are not the only expert in the room; in fact, the person living with the disability has the most expertise on their own experience and identity. For example, while person-first language was long considered the clinical and educational standard (Jensen et al., 2013), the Autistic community has led a shift toward identity-first language, viewing their neurodivergence as an inseparable part of their personhood (Best et al., 2022). The ethical practitioner will defer to the individual's preference, recognizing that the community is not a monolith.

Furthermore, self-reflection must be treated as a necessary and integral component to clinical and educational practice. Rather than following a checklist, the practitioner is called to enter a contemplative state, interrogating the uncomfortable possibility that they may subconsciously view disabled bodies as lacking the capacity for sexuality. The practitioner must ask if they perceive a disabled person's sexual desire as a sign of immaturity or, conversely, as a manifestation of hyper-sexuality. They must confront biases regarding whether they believe sex is only possible for disabled people through paid services, or if they hold gendered assumptions that imply men with physical disabilities struggle more with performance than women. Table 1 provides a brief overview of some longheld assumptions and the affirming practitioner response.

Table 1: Challenging Assumptions with Affirming Practitioner Responses

Assumption	Affirming Practitioner Response
Infantilization: Viewing disabled adults as asexual, eternal children who have no interest in or need for sex.	Sexual Citizenship: Acknowledging that sexuality is an essential human right for all, regardless of disability.
Hyper-sexualization: Viewing disabled people as having uncontrollable urges or being sexually deviant/promiscuous	Nuanced Identity: Recognizing that sexual desire and expression are normal parts of human diversity, regardless of disability.
Harm-Reduction Model: Focusing education only on preventing abuse and assault.	Sex-Positive Model: Promoting a positive sexual identity, intimacy, connection, pleasure, and autonomy alongside safety
Deficit View: Seeing disability as a brokenness or a negative condition that must be cured	Disability as Identity: Viewing disability as a point of diversity and a rich cultural identity to be celebrated
Practitioner as Authority: Viewing themselves and/or their professional community as the sole or most valuable expert.	Collaborative Expertise: Recognizing people with disabilities have relevant expertise and should be equal collaborators.

Finally, care must be both affirming and trauma-informed, paradigms that are deeply and necessarily intertwined for the disabled community. In contrast with the medical model, which views disability as a deficit or deviation to be cured (Stuntzer & Hartley, 2014), disability-affirming care honors disability as a valid point of diversity and pride. In clinical settings, this care is more than just idealism, it is a safety mechanism for a highly vulnerable population. Under the paternalistic medical model, people with disabilities are routinely denied bodily autonomy and infantilized, a systemic denial of agency that directly contributes to their ongoing abuse. Indeed, a staggering 83% of women with disabilities will experience sexual assault in their lifetimes (Disability Justice, n.d.). Because the medical model inherently denies the agency and very humanity of people with disabilities, true trauma-informed care for this population is impossible without a disability-affirming foundation that restores their sexual and general autonomy. In clinical settings, this means understanding that sexual topics can be highly triggering. Practitioners may consider allowing disabled clients to broach the topic of sex first, remaining a steady, non-judgmental presence as they process the layers of historical and personal trauma that often surround disabled intimacy. Likewise, in educational settings practitioners must also understand the upsetting nature inherent in these discussions, particularly for individuals who have historically been denied the language and space to understand their own bodies. It is important to develop strategies, like having counseling services immediately available, if a topic becomes too intense or triggers prior trauma.

CONCLUSION

The proposed reflective prompts and considerations represent an important step in becoming an ethical practitioner for people with disabilities. Ultimately, however, the transition from individual reflection to broad systemic advocacy is becoming increasingly necessary in a society that remains so conflicted about disabled agency and autonomy. The paradigm shift toward affirming care presented above is a vital safeguard for the rights of a community that has long been targeted for exploitation, control, and erasure. The urgency of this shift is underscored by the reality that the historical mechanisms analyzed throughout

this work are not merely relics of the past, but are currently experiencing a dangerous resurgence.

As disabled self-advocates like Imani Barbarin (2022) and academics like Adam Rutherford (2022) have been saying for years, eugenics does not live only in the history presented above. In fact, as Barbarin explains, societies around the world are following a historical pattern marked by a stark rise in eugenics following a pandemic. If this pattern mirrors the response following the 1918 flu pandemic, it could lead directly to the reinstitutionalization and genocide of anyone deemed inferior (Barbarin, 2022); the fairytale turns into a nightmare. It is possibly more important than ever that educational, clinical, and other practitioners reify a commitment to the disabled community that rejects eugenics outright, despite its increase in popularity among tech oligarchs and authoritarian regimes in power (Caplan & Tabery, 2024; Gray, 2022).

The history of the disability community is one of remarkable resiliency against a backdrop of systemic sexual oppression. From the "eternal child" tropes of the freakshow era to the legislative battles for sexual autonomy in the 21st century, disabled individuals have consistently fought to be recognized as equal citizens, let alone sexual citizens. This narrative analysis reiterates that sex positivity is a fundamental human right that must be extended to all bodies. For the practitioner, the path forward is one of active empathy and the rejection of the eugenics-based medical model in favor of a humanistic, affirming approach. By recognizing that disabled people themselves are the primary experts on their own lives and bodies, practitioners can assist in dismantling the barriers that have for too long silenced the fairytale of disabled love and intimacy.

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