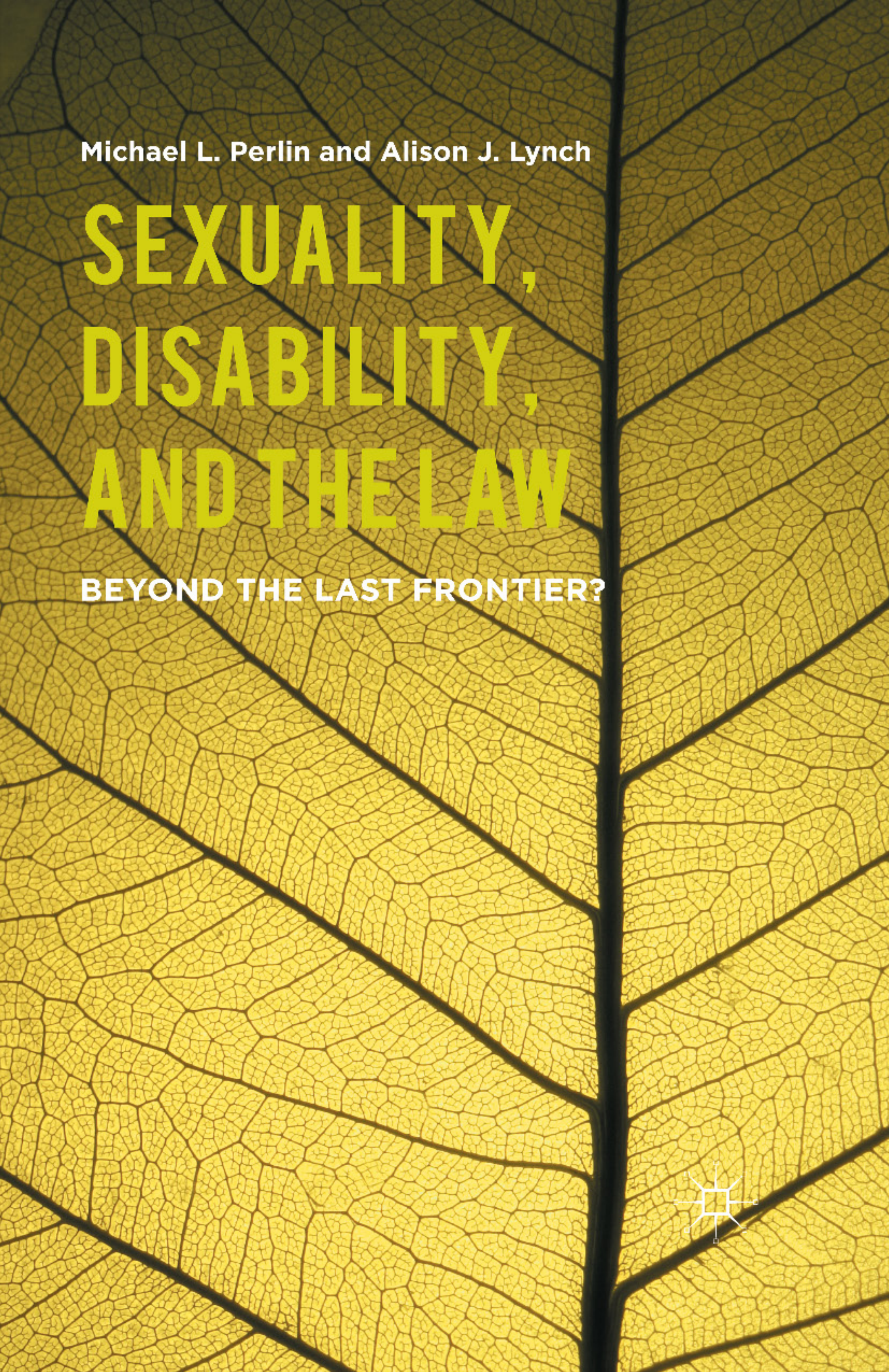

Michael L. Perlin and Alison J. Lynch

SEXUALITY, DISABILITY, AND THE LAW

BEYOND THE LAST FRONTIER?

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Softcover reprint of the hardcover 1st edition 2016 978-1-137-48107-8

First published 2016 by
PALGRAVE MACMILLAN

Palgrave Macmillan in the UK is an imprint of Macmillan Publishers Limited, registered in England, company number 785998, of Houndmills, Basingstoke, Hampshire, RG21 6XS.

Palgrave Macmillan in the US is a division of Nature America, Inc., One New York Plaza, Suite 4500, New York, NY 10004-1562.

Palgrave Macmillan is the global academic imprint of the above companies and has companies and representatives throughout the world.

ISBN 978-1-349-69413-6
E-PDF ISBN: 978-1-137-48108-5
DOI: 10.1057/9781137481085

Distribution in the UK, Europe and the rest of the world is by Palgrave Macmillan®, a division of Macmillan Publishers Limited, registered in England, company number 785998, of Houndmills, Basingstoke, Hampshire RG21 6XS.

Library of Congress Cataloging-in-Publication Data

Names: Perlin, Michael L., 1946- author. | Lynch, Alison J., author.
Title: Sexuality, disability, and the law : beyond the last frontier? / Michael L. Perlin and Alison J. Lynch.
Description: New York, NY : Palgrave Macmillan, 2016. | Includes bibliographical references and index.
Identifiers: LCCN 2015028056 | ISBN 9781137481078 (hardcover : alk. paper)
Subjects: LCSH: Mental health laws. | People with mental disabilities—Sexual behavior. | Sexual rights. | Human rights.
Classification: LCC K3608 .P47 2016 | DDC 344.04/4—dc23 LC record available at http://lccn.loc.gov/2015028056

A catalogue record of the book is available from the British Library.

From MLP to Linda, Julie, and Alex: You are my soul, my heart and my foundation. None of what I have done would have ever been possible without your love and encouragement and great senses of humor. I could not be luckier. And what a treat it has been for me to work with AJL on this project; I can't wait for the next one!

From AJL to my family: Thank you each for your unwavering support throughout this project—my first book!—and as I begin my career, your willingness to be my sounding board at every step, and the love and generosity you each have shown in so many ways. To MLP: Thank you for taking a chance on me when I came into your office as a 1L, and inspiring me to think big and dream bigger. I have learned so much from being your coauthor and am incredibly appreciative of our partnership.

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Acknowledgments

We wish to thank our research assistants and colleagues who have worked on these issues with us for the past two decades: student assistants Jackie Halpern Weinstein, Jessica Cohn, Naomi Weinstein, Rose DiBenedetto, Ilene Sacco, and Monica Studdert; and colleagues Susan Stefan, Doug Mossman, David Wexler, the late Bruce Winick, Keri Gould, and New York Law School Adjunct Professor Heather Ellis Cucolo. Our thanks to David Wexler and to the late Bruce Winick especially for their vision in the creation of the field of therapeutic jurisprudence, and for welcoming MLP as a fellow traveler from the start. MLP adds special thanks to Bob Sadoff for 40-plus years of friendship, mentoring, and support (and baseball games). We also appreciate the assistance of forensic psychologists Dan Murrie, Ellen Kohitus, Mindy Mechanic, and David Thompson, in their gracious responses to our last-minute requests for some reference sources that we were not able to otherwise locate.

We want to offer special thanks to Carolyn Hasselmann, Joel Dvoskin, New York Law School Adjunct Professor Debbie Dorfman, and Eleanore Fritze. Carolyn has done an absolutely spectacular job in her role as research librarian assistant at the New York Law School library. Over 20 years ago, at Joel's urging and prodding, this project was first begun, and we are sure it never would have come to life this way were it not for him. Debbie has practiced mental disability law in many states, and, as we will discuss in subsequent chapters, her constant and persisting advocacy in this area has given us hope that our writings may eventually make a difference. Eleanore directs the Mental Health Advocacy program for Victoria Legal Aid in Australia, and has provided us with a steady stream of articles, press clippings, and hospital policies from that nation that helped so much in the shaping of the final project and most likely would have otherwise escaped our attention entirely. We are so appreciative of all that they have done for us.

1

Introduction

One of this book's coauthors (MLP) was recently on the train. He opened his briefcase and took out an academic book on sexuality and disability. The woman sitting next to him (dressed in a business suit and working on spreadsheets on her laptop) looked over and asked, "What on earth is that?" He responded, "A book about sexuality and disability." She: "Why are you reading that?" He: "Well, a colleague and I are working on a book on the same topic." She: "I think that's *disgusting*. If God had intended them to have sex, he wouldn't have made them disabled." He: "Have a nice day."

When the coauthor got home, he immediately emailed the other coauthor (AJL) and said, "We have the opening paragraph of our book." And we do.

But we should not have been surprised. An article published in early 2014 in a peer-reviewed scientific journal began with the startling comment that "the recognition that individuals with disabilities have a *desire* for sexual relationships with other people is a relatively new concept in the scientific community" (Gilmour et al., 2014, p. 569, emphasis added). This is consistent with the opinions revealed during countless presentations at which audience members have, time after time, expressed the view that "these people [*sic*] have no sense of sexuality; you're making a big deal out of nothing" (Perlin, 2005b, p. 35).

When one of the coauthors (MLP) spoke about this topic to a public audience at the Florida Mental Health Institute (part of the University of South Florida in Tampa) some years ago, an audience member (from the general public) leaped to his feet and denounced him: "Professor Perlin, you are an agent of the devil!" At a New York City hospital presentation, a nurse folded her arms across her chest and announced, "Professor, you are the very embodiment of evil!" (id., p. 35). A nurse at a New Jersey state hospital told him that "God explicitly forbids what you are talking about," the nurse adding that he would "pray for [MLP's] soul" (id., p. 38).

Debbie Dorfman, a veteran mental disability rights litigator, tells the story of a case she did in Santa Clara, California, in which she engaged in a lengthy series of negotiations with the managers-owners of board-and-care homes (facilities to which ex-hospital patients were deinstitutionalized, but in which they lived involuntarily for months or years, often for much longer than they spent in hospitals), as a result of which residents were allowed privacy for sexual interactions with other residents or with their loved ones who were not in the facilities in question. She accomplished this at almost all the homes, save for one where the owner was adamantly against letting patients have sex. Debbie argued and negotiated, and, finally, the owner told her, "OK, Ms. Dorfman, you win. Patients at my facility can have sex on Saturday evenings from 6–8 p.m." Debbie asked, "Why then?" Because, the owner responded, "that's when my wife and I do it. If it's good enough for us, it's good enough for them" (id., p. 36). When the issue of patient sexuality was raised to a nurse at a state hospital, she responded, "Are you suggesting that the state run a brothel?" (Mossman et al., 1997, p. 444, citing Wasow, 1980). When doctors at state psychiatric institutions are asked about this issue, the typical response is "not at *my* hospital," citing potential liability fears (physical/emotional injury, unwanted pregnancies, spread of sexual diseases) (id., p. 441).

These stories and anecdotes (which we do not think are atypical in the least), in the aggregate, reveal some important truths:

- The question of the sexual rights of persons with disabilities—especially, persons *institutionalized* because of *mental* disabilities—is inevitably considered in the context of other opinions and other values.
- There is a significant **fear** that, if any sort of sexual autonomy is allowed, hostile litigation will follow (a fear that, empirically, is utterly groundless and that ignores the fact that the *denial* of these autonomy rights might well lead to litigation based on constitutional and statutory theories and may likely, in fact, violate international human rights).
- There is a strong component of **religiosity** present when many people are confronted with this issue. The use of the words "God," "devil," and "soul" in the conversations reported upon make it clear that the speakers—whose positions reflected views expressed dozens and dozens of time—see *this* sort of sexual activity as being against the precepts of some religion (although it has never been suggested that such activity is proscribed in any bible or other book of worship).
- The response of the board-and-care home manager reflected **projection** ("if it's good enough for me and my wife"). Other examples

are important (albeit less memorable). When one of the coauthors (MLP) spoke about this topic at an American Psychiatric Association annual meeting, the only comment from the audience was from an APA member who criticized the paper for not directly addressing the special issues raised in the cases of gay patients. At a talk to a major nationally based patient advocacy organization, he was challenged by an audience member who saw "nothing wrong" with staff members having sex with patients, accusing him of being sanist[1] in arguing for a total ban on such activity. When questioned, the audience member answered, "Well, I can see myself wanting to have sex with a patient. Who are you to tell me I can't?" The coauthor had no response as to his desire but did as to his proposed plan of action (making it clear that any hospital sexuality policy should absolutely forbid such relationships).

- There is a great undercurrent of **anger** in the responses discussed above (the "agent of the devil" comment being the most pointed). But, for the 40 years that MLP has been discussing patients' rights issues, he has never experienced the constant level of anger—not so much at his position, but at his having the temerity to *raise the issue*—that he has when discussing this topic.
- Both the lay and professional responses also reflect **denial** (the expressions of surprise that patients are sexual beings). Two other radically different stories reflect this reality. At a Grand Rounds talk at Rochester Psychiatric Hospital done by a coauthor (MLP), a young psychologist got up and said, very matter-of-factly, "I don't get it. Sex isn't very important anyway. What's the big deal?" (Perlin, 2005b, p. 45), making it clear in the follow-up colloquy that she was referring globally to sex (and not simply to sexual interaction between patients). Some years later, the same coauthor (MLP) was on a site visit at a psychiatric institution in Montevideo, Uruguay, visiting a ward that housed "high-functioning" teenage males.[2] When asked about patient sexuality, a staff worker responded, angrily, "Please! There's not one of them interested in sex!" He then walked into the dayroom, where a music video was on the TV (a far more R-rated video than one might see on MTV or VH-1), including a scene of two teenage girls kissing passionately and deeply. Judging by the expressions on the boys' faces, their agitation, and their comments to their ward mates, the staff member could not have been more wrong.
- It is fairly clear that a significant amount of **transference/countertransference** is occurring. When one of the coauthors (MLP) spoke about this topic at a major New York hospital, he noted that, besides himself, at that time, only one other law professor (Prof. Susan Stefan,

> then at the University of Miami Law School, see, for example, Stefan, 1989), had shown any interest in this topic. An audience member immediately jumped up and said, "No, Professor. What's much more interesting is why you and Professor Stefan are so obsessed with this topic." (In response, the coauthor reached his hand into his suit jacket pocket, pulled out an envelope, and said, "Here's my honorarium. Would you like to do a session now?" When he got home, and he told the story to his wife [a psychotherapist], she said, "No, what you should have said is, 'Actually, doctor, the more interesting question is why you are so obsessed with what you perceive as my obsession.'"

How did we get involved in this area of law and policy in the first place? One of the coauthors (MLP) can pinpoint it precisely. On a warm spring night in 1979, he and a colleague went to Marlboro Psychiatric Hospital (at which many of our clients resided)[3] to discuss a tentative class action settlement (on a very different legal issue: the right of patients to be paid for work they did from which the hospital obtained consequential economic benefits, see *Schindenwolf v. Klein,* discussed in Perlin, 1976). We met with the governing patients' council members (about 25–35 at the time that the hospital's population was well over one thousand patients). We met on the porch of a sprawling, Victorian building that the hospital used for patient activities, and explained who we were, why we had brought the case, why we were settling rather than going to trial, what the settlement entailed, and why we were there for input (on why it is critical for counsel to consult with clients in public interest/class action litigation, see Berger, 1978; Southworth, 1999). As we talked, the coauthor kept scanning the porch, making eye contact, wondering if there would be patients (as there had been at every other facility we had visited) who would come up to us at the end of our visit to tell us about other issues, potential lawsuits, whatever.

But, as this was happening, his attention was arrested by the sight of a young couple kissing passionately and fondling each other. The couple was most likely in their mid-20s, and were, as objective as one can be, quite attractive. They were seated in the middle of a middle row and were surrounded on all sides by other patients, who ranged in age from 18 to 65 plus. Also, and significantly, neither was beset by the ravages of tardive dyskinesia, from which so many patients suffered at that time (compare *Rennie v. Klein,* 1999; patients at the hospital in question were members of the *Rennie* class). This is important because the couple looked "different" from the vast majority of our clients, and, 35 years later, there is still the open question as to whether the reaction to this scene would have been different if this couple had not presented in a physically attractive way.

The coauthor tried very hard not to stare, but it was difficult. First, their behavior was totally unexpected. Also, as he observed what was going on, he was thunderstruck by what he instantly realized was something that he had not witnessed, and failed to realize that he had not witnessed, in all of the work that he had done representing patients in psychiatric hospitals over the prior eight years. This was the first time that he saw patients express physical affection for each other. He realized instantly that this was a clue to understanding the hidden world of the state psychiatric institution.

At the end of the presentation, he spoke to a patient who, although not a named plaintiff, was one of the key client-witnesses in the underlying case and asked him whether he knew the couple. He said that he did and that their story was well known to many hospital residents: They were from the same home town, knew each other in high school, but became a couple only after they were institutionalized. He explained that what was observed was "pretty tame," compared to what happened occasionally on field trips or during "free time" (the hospital campus covered many acres with many relatively out-of-eye-range nooks and crannies), but, he surmised that the couple was on "good behavior," because "you guys were lawyers and all."

The coauthor drove home in a half-daze, reflecting on what he had seen that night, and everything that he had *not* seen over the prior eight years. At that time, New Jersey's psychiatric hospitals ranged from total maximum security to medium security to open ward. Now so much became clear. He recalled having clients come to see him in an unused dayroom or cafeteria or library (wherever there was some minimal privacy for lawyer–client discussions), furtively tucking in shirttails, arranging blouses, blushing. Now it all made sense. He was mortified and chagrined that he had never "gotten it" before, that he had never even thought about, let alone realized, what had been going on. And certainly, there was no hospital policy addressing the issue of "patient sexuality." Indeed, the few policies that existed at that time at other hospitals did little more than forbid any sort of interaction (Perlin, 1993–94).

The next day, when the coauthor went to his office, he told some of his colleagues what had happened and found the responses to be interesting. Some said, "Sure, that makes sense," but others said, "Leave it alone!" reasoning that, if we were to raise this issue in public, we might have to weather a firestorm of criticism, especially from conservative legislators, that might threaten our agency' s existence.[4] Still others said, "Back burner it; we've got too many other cases on our docket now." So we decided that we would approach the issue quietly; we would ask our "field representatives" (psychologists, social workers, and psychiatric nurses) to be especially alert for client complaints, or even stories that dealt with questions of sexuality on hospital wards.

After a few weeks, it became clear that inquiry was going to be difficult and challenging. Most of our staff reported that there were no complaints; the few who had learned of complaints were quickly told that the patient did not want to "rock the boat" or "make waves." But all agreed that this was an important issue; there was simply no way to raise it.

Some five years later, when the coauthor became a professor at New York Law School, he began to teach mental health law, and regularly assigned to students to read (for the first day of class) Susan Sheehan's magnificent book, *Is There No Place on Earth for Me?* (1983), the story of "Sylvia Frumkin," a brilliant but seriously mentally disabled young woman who was a chronic (albeit atypical) patient at Creedmoor State Hospital in New York City. Sheehan did not flinch from looking at the issue of patient sexuality, noting that hospital staff aides often refused to fill out "incident reports" on patient sexual activity because they found the subject matter "so unsavory," and further noting that one of the many "sexual escapades . . . [involved] two staff members [who] were injured when they went into the men's bathroom to separate [a patient] and his willing partner" (id., p. 92).

When we discussed the book in class, students were asked which issues that Sheehan had raised did they think were the most important. Invariably, the blackboard would fill with 20–30 legal issues, but never did a student spontaneously and voluntarily raise the issue of patient sexuality. When mentioned, it usually got blank stares. Occasionally, a student would add a few words about the significance of sexuality to all persons, but, all too often, the only comment would be something on the level of "Eww, gross!"

At about the same time, the coauthor began to talk about patient sexuality issues with his friend Joel Dvoskin, who was then associate commissioner in charge of forensic services of the New York State Office of Mental Health. We had been discussing the issue of patients' access to condoms at a time when it was generally assumed that condoms would not be made available to patients in many forensic hospitals and that they should actually be treated as contraband. Politically, providing or allowing condoms in a state-run forensic psychiatric facility was likely to be viewed as "condoning" sex among patients. This was, Joel said, "a very complicated issue":

> On one hand, many of our patients were quite vulnerable, and some had been sexually victimized many times in their lives, as children and as adults. Others had long records of predatory sexual behavior, within and without correctional environments. I believed that I had a duty to protect my vulnerable patients from harm. On the other hand, I was well aware of the fact that in any large facility, it would be virtually impossible to successfully prevent all forms of sexual contacted among the patients. If I were to agree that condoms were contraband, it seemed to me that I might be contributing to

> the spread of HIV, which was then presumed to be a fatal disease (Dvoskin, 2004, email, quoted in Perlin, 2005b, p. 33).

Further, Joel pointed out that there was virtually no legal or psychiatric literature to which he could turn for guidance on such an important question, and then he suggested thinking about the broader issues of patient sexuality more fully (commenting, drily, "Hey Michael, you have tenure now. What can they do to you?"), followed by extending an invitation to MLP to give a Grand Rounds presentation at Kirby Forensic Psychiatric Center on the topic.

When MLP started working on this, he began his research (his research assistant immediately told him that some of her classmates offered a variety of snide comments when she told them of the assignment) and prepared to write the Grand Rounds paper. But, before he did, something remarkable happened at his office, which he subsequently recounted in an article about how sanism permeates law teaching:

> I was sitting at my faculty lunch table, and conversation turned to upcoming presentations that we would soon be doing. My colleagues mostly take left-liberal positions on a wide variety of issues, and are generically the exact mix of retro 1960s generationists and early baby boomers that you'd expect. They (appropriately) are quick to criticize any behavior that is racist, sexist, ethnically bigoted, or homophobic. Rush Limbaugh would probably view them as one of his worst "politically correct" horror fantasies. I'm not terribly out of place in this group.
>
> When it got to be my turn, I said that I was going to be speaking about the right of institutionalized mentally disabled persons to sexual interaction. All conversation came to a screeching halt. "Michael, are you serious?" "Are you crazy (sic)?" "Michael, even for you, you've gone too far!" "What are you going to say next: that they can get married?!?" Et cetera. (Perlin, 2003e, p. 714)

In discussing this, MLP has noted further:

> At this stage of my life and career, few things surprise me. Yet, I must admit that I was stunned—not by the response (I spend lots of time in places where few people agree with me about anything, so I don't expect, or want, agreement with whatever it is I'm talking about), but by the identity and background of the people who were uttering these sentiments. As I've said, these were classic New York liberals, many of whom had spent much of their distinguished professional, academic and personal lives rooting out and exposing prejudiced and stereotypical behavior toward virtually every minority group one could imagine. The buck, though, stopped there (id.).

When MLP did his initial presentation on this topic[5] at Kirby Hospital, the talk lasted 45 minutes, and he then asked, innocently, "Are there any questions?" After 75 minutes of questioning, the program host pointed out that another meeting was scheduled for the room, and we thus had to stop (though there were still at least a dozen hands waving). This had clearly tapped a hidden issue that screamed out for debate. The audience was composed of forensic mental health professionals who worked at Kirby (psychiatrists, psychologists, nurses, allied therapists, therapy aides), hospital administrative staff, and a few lawyers who frequently represented Kirby patients. And that led to multiple presentations before audiences at hospitals, state agencies, professional associations, advocacy groups, and law schools across the nation and internationally, audiences that have reacted in radically different ways, as discussed above (Perlin, 2005b).

The other coauthor (AJL) has far less personal experience to draw from in this realm as she has only been a licensed, practicing attorney for two and a half years at the time of publication. However, she has observed the detrimental effects of policies based on fear, religion, and sanism in her work in New York and New Jersey hospitals on behalf of institutionalized patients. While the issue of sexual autonomy has never been raised directly to her by a patient (which is an interesting observation, generally, and worth looking at why that may be), she has observed and encountered some willingness to discuss this issue among other like-minded attorneys and treatment providers who frequently work with individuals with mental disabilities. However, very little seems to be done in the way of seeking and affirmatively seeking policy changes or recognition of this particular type of patient autonomy that could lead to concrete implementation of changes in how staff responds to this particular right. She believes that it is just as important to bring attention to these issues as it is to shed light on all of the other rights than institutionalized individuals maintain before they entered the hospital.

We are now writing this book for multiple reasons. Our research and our field work have shown us—beyond any doubt—that the pernicious impact of sanism has colored and poisoned this entire area of law and policy. Our society thus labeled individuals with mental illness as "deviant, morally weak, sexually uncontrollable [and] emotionally unstable" (Perlin, 1992b, p. 393). Or, on the other hand, we objectify this population as asexual (Hahn, 1994; Deegan, 1985). And often, we (especially professionals) regard them as not being human at all and lacking human qualities including needs for affection and dignified ways of expressing affection. There is no question that the issue of consensual sexual relationships between adults with mental illness is a highly charged, emotional issue (Dobal and Torkelson, 2004). Agnes Higgins and her colleagues have perceptively characterized this entire area of policy as one of *veiled sexualities*, as "it allows for some vision or some knowledge of the subject, however obscured" (Higgins et al., 2008, p. 309). No group faces the same sort of sexual and reproductive restrictions as are faced by persons with disabilities (Ailey et al., 2003).

Our attitudes toward the sexuality of persons with mental disabilities reflect this labeling (Perlin and Lynch, 2014, pp. 259–60):

> Society tends to infantilize the sexual urges, desires, and needs of the mentally disabled. Alternatively, they are regarded as possessing an animalistic hypersexuality, which warrants the imposition of special protections and limitations on their sexual behavior to stop them from acting on these "primitive" urges. By focusing on alleged "differentness," we deny their basic humanity and their shared physical, emotional, and spiritual needs. By asserting that theirs is a primitive morality, we allow ourselves to censor their feelings and their actions. By denying their ability to show love and affection, we justify this disparate treatment. (Perlin, 1993–94, p. 537; see also, Neuhaus, 2012, p. 190: "Women with disabilities may be stereotypically perceived as asexual or hypersexual.")

So what conclusions can we draw from all of this? First, this is "a public policy question as controversial as they get" (Perlin, 1993–94, p. 520, quoting Kawrath, 1989, p. 1), one that so many wish would just "go away" (see Perlin, 1993–94, p. 534; Kulick and Rydstrom, 2015, p. 84–86).

Second, this remains a woefully (perhaps "tragically" is the right word) underconsidered area of law and social policy. The fact that there is no currently available book-length treatment of this subject astounded us, and we hope this helps fill an important gap. Third, we have learned that the mere *mention* of this subject is an amazing projective test as to others' views, not just on the relationship between sexuality, disability, and the law, but also on a range of other social policy topics (e.g., gender role issues, the appropriateness or inappropriateness of hospital policies—or any policies—based on religious views, and acceptance of nonmainstream activities—sex for persons with disabilities). The detrimental laws that *do* exist remain so underdiscussed because we are still so astonishingly uncomfortable thinking about the questions at hand. We want to close our eyes to the reality that persons with mental disabilities are sexual beings, and we want to close our eyes even more to the fact that their sexuality may be much more like "ours" than it is different. There is no question; the sexuality of persons with mental disabilities is one of the "most threatening issues confronting clinicians, line workers, administrators, advocates, and attorneys who are involved in mental health care related work, as well as the families of individuals with mental disabilities" (Perlin, 1993–94, p. 520). We must deal with this constantly.

Fourth, it does not appear that changes in patients' rights law, changes in competency assessments, and creation of sophisticated, valid, and reliable research instruments that measure attitudes toward social behaviors have ever been applied through the filter of patient sexuality issues. Fifth, developments in international human rights law force us to reconsider these issues in ways that we have simply not thought of before, making us confront the reality that many policies in many psychiatric institutions around the world violate these rights, especially the United Nations' Convention on the Rights of Persons with Disabilities (see Perlin and Lynch, 2014). Sixth, much of the theoretical scholarship that has been done in the area of disabilities studies (often self-described as "crip theory") pays no attention to issues that involve persons with *mental* (as opposed to *physical)* disabilities (Löfgren-Märtensen, 2013).

Seventh, it is clear there is *no* unitary definition of competency in this area. Often, there are *no* definitions, and, when there *are* definitions, they are often circular and contradictory. Eighth, there is a whole range of issues to be considered in determining "sexual competency," but, as the cases we will be discussing should make clear, these factors change from case to case, jurisdiction to jurisdiction, and substantive topic to substantive topic. Where policies do exist, they are often stigmatizing and marginalizing and do not allow for the range of opportunities to engage in sexual activities afforded to those without mental disabilities (Perlin and Lynch, 2014, p. 300). And ninth, the recent growth and expansion of the school of therapeutic jurisprudence leads us to consider anew questions of voice, of voluntariness, and of validation (Ronner, 2008, p. 627; Perlin and Lynch, 2015a).

The *basso continuo* in this entire investigation is an acknowledgment that, to many, the whole *idea* of persons with mental disabilities having sex is *transgressive*. Transgression has been increasingly recognized by social scientists as a key aspect of analyzing "sexual transformations" (Donnan and Macgowan, 2009, p. 3). As sexual encounters "invoke uneasy tensions between consent, demand, resistance and reciprocity, in which elements of domination, vulnerability, risk and safety all play a part" (id.), it is no wonder that the notion of transgression goes to the core of what we are exploring here. Donnan and Macgowan accurately characterize sexual transgression as "an enticing and hazardous proposition" (id.); the sexual acts that we discuss here—in the specific context of who the participants are—"cross boundaries and . . . have the potential to challenge . . . moral, legal, social, economic, political, ethnic [and] racial limits" (id., p. 4). We believe that recognizing the stigma—which is rarely, if ever, acknowledged or discussed—that is attached to these transgressive acts is an important step to ensuring that individuals with disabilities, in and out of institutions, have equal opportunities to express and engage in sexual behaviors. Especially since sex is used "as a means of labeling and separating people"

(Hodges, 2015, p. 418), the issues we raise in this book reflect a whole constellation of social values—about rights, liberties, and emancipation.

The book will proceed in this manner. In Chapter 2, we discuss the four factors—sanism (already mentioned), pretextuality, heuristic reasoning, and false "ordinary common sense" (OCS)—that contaminate *all* mental disability law (see, e.g., Perlin, 1999a), but *especially* the law of sexuality and disability. (e.g., Perlin, 2008b). In Chapter 3, we consider the underlying issues from an array of legal perspectives—that of patients' rights law, of antidiscrimination law, of competency law, of sterilization law, of medication side effects law, of reproductive technology and rights law, of international human rights and comparative law, of tort law, of administrative law, of the laws that govern patient life in forensic facilities, and of issues of risk. In Chapter 4, we focus on a wide array of social policy issues and how *fear* has always animated these policies. We discuss this in the context of personal issues (including masturbation, procreative rights, and abortion rights), in the context of issues that affect others (including sex education and sex surrogacy), and in the issues that implicate other areas of the law (torts and administrative law).

In Chapter 5, we tackle issues of gender, society, and sexuality, looking foremost at historical and contemporary *attitudes* towards sex (including religious attitudes), at how we conceive of sexualization and desexualization), the enjoyment of sex, the sexual abuse of persons with disabilities, the impact of disability on sexual functioning, the special issues that emerge in consideration of persons with autism, and how these issues are resolved in facilities other than psychiatric hospitals (jails, prisons, facilities for persons with intellectual disabilities), and, finally, what do we really mean by "sex," with some consideration of how we feel about different sort of sexual activities (especially sexual activities that are not typically denominated as "vanilla," and the roles of gender issues and gender preference issues in resolving these questions). In Chapter 6, we will carefully discuss the significance of therapeutic jurisprudence (TJ) in the resolution of all these issues will evaluate them all through a TJ filter, and then offer our conclusions.

We have, of course, considered many of these issues before in other articles. This chapter draws on and "Sex on the Wards: Conundra for Clinicians," *Journal of the American Academy of Psychiatry and Law* 25:441 (1997) (with Douglas Mossman, MD and Deborah A. Dorfman, JD) and "'Limited in Sex, They Dare': Attitudes toward Issues of Patient Sexuality," *American Journal of Forensic Psychiatry* 26:25 (2005b). Chapter 2 builds on *A Prescription for Dignity: Rethinking Criminal Justice and Mental Disability Law* (*Prescription)* (Ashgate, 2013a). Portions of Chapter 3 incorporate positions we have taken in "'All His Sexless Patients': Persons with

Mental Disabilities and the Competence to Have Sex," *Washington Law Review* 89:257 (2014) (*Sexless*); "'Make Promises by the Hour': Sex, Drugs, the ADA, and Psychiatric Hospitalization," *DePaul Law Review* 46:947 (1997a); "'Love Is Just a Four-Letter Word': Sexuality, International Human Rights and Therapeutic Jurisprudence," *Canadian Journal of Comparative and Contemporary Law* 1:8 (2015b) (*Four-Letter);* "Sexual Activity among Psychiatric Inpatients: International Perspectives," *Journal of Forensic Psychiatry* 4:109 (1993); "'Everybody Is Making Love/Or Else Expecting Rain': Considering the Sexual Autonomy Rights of Persons Institutionalized Because of Mental Disability in Forensic Hospitals and in Asia," *Washington Law Review* 83:481 (2008b), and in *Mental Disability Law: Civil and Criminal* (3d ed. 2015) (in print). Some of Chapters 4 and 5 rely on "Hospitalized Patients and the Right to Sexual Interaction: Beyond the Last Frontier?" *NYU Review of Law and Social Change* 20:517 (1993–94). Chapter 6 expands on thoughts first developed in *Four-Letter*, *Sexless*, *Prescription*, and "'There Are No Trials Inside the Gates of Eden': Mental Health Courts, the Convention on the Rights of Persons with Disabilities, Dignity, and the Promise of Therapeutic Jurisprudence," in *Coercive Care: Law and Policy* p. 193 (McSherry and Freckelton, eds., 2013d, Routledge).

We do not want the reader to be left with feelings of hopelessness. When we speak about these topics, invariably a significant number of audience members often express enthusiasm, and it is not unusual at all for listeners to come forward and say, sotto voce, "I definitely agree with you, but it is impossible to convince anyone at my hospital to change!" It perhaps is of interest that those who respond favorably are generally psychologists, social workers, and patient advocates (and, probably, 90 percent have been female). We have also been overwhelmed by the response of audience members who identified themselves as persons with disabilities and, speaking from the audience for all in attendance to hear, have told moving stories of their attempts to maintain relationships (despite opposition from family members, staff, and others), which, in some cases, have resulted in marriage and the birth of children (Perlin, 2005b, p. 40).

We noted earlier in this chapter that the sexuality of persons with mental disabilities is one of the most threatening issues confronting mental health professionals, lawyers, and family members (Perlin, 1993–94, p. 520). We understand that. But we also understand that this cohort of marginalized, misunderstood, trivialized citizens has legal, social, and human rights that require vindication. We hope that, in some modest way, this book helps that cause.

2

The Four Factors: Sanism, Pretextuality, Heuristics, and "Ordinary Common Sense"

I. Introduction: Why the Critical Factors?

It is impossible to make any conceptual sense of the relationship between mental disability and any aspect of the law without an understanding of four critical factors that dominate—and control—this relationship. And this applies with even more power to the topic under consideration in this book: the sexuality rights of persons with mental disabilities. What is most vexing is that these factors often exercise this domination in an invisible manner (Perlin, 2000d). We have been writing about these factors—sanism, pretextuality, heuristics, and "ordinary common sense"—in different guises for over two decades (Perlin, 1992b, 1991b, 1990b) and continue to write about them in different contexts to this date (Perlin and Lynch, 2014, 2015b; Perlin, 2011b; Perlin and Dorfman, 2011; Cucolo and Perlin, 2012, 2013; Perlin and Weinstein, 2014).

Unless and until we fully understand the malignancy of sanism and pretextuality, and the ways that heuristic reasoning and false "ordinary common sense" cause us to make and to reinforce biased and irrational judgments, we are doomed to repeat the errors that we continue to make in the way we deal with questions of patient sexuality, for sanism denies institutionalized persons "the rights to their own sexuality" (Perlin and Lynch, 2015b, p.41). We also must consider how these factors diminish the likelihood that we will treat the population in question with the level of dignity that the law (and authentic common sense) should demand (Perlin, 2000a); "dignity concerns and rights violations will occur if there is not a full understanding of the importance of the ability for persons with mental illness to practice free sexual expression" (Perlin and Lynch, 2014, p. 261).

II. The Factors

A. Sanism

"Sanism" is an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry. It infects both our jurisprudence and our lawyering practices.[1]·Sanism is largely invisible and is largely socially acceptable. It is based predominantly on stereotype, myth, superstition, and deindividualization, and is sustained and perpetuated by our use of alleged "ordinary common sense" (OCS) and heuristic reasoning in an unconscious response to events both in everyday life and in the legal process. Deindividualization comes about because we see persons with mental disabilities as alienated from mainstream society, and as, in Sander Gilman's phrase, "the Other" (see Perlin, 1998b, p. 787, discussing Gilman's insights in this context). Discrimination pervades the lives of people with a psychiatric diagnosis (Stefan, 2003). Importantly, sanism has never been taken as seriously as racism, sexism, or homophobia, other than by (1) persons with disabilities, (2) their families (in some cases), and (3) their advocates.

Consider the roots of the assumptions that are made by the legal system about persons with mental disabilities—who they are, how they got that way, what makes them different, what there is about them that lets society treat them differently, and whether their condition is immutable (Minow, 1990; Gilman, 1985). These assumptions—that reflect societal fears and apprehensions about mental disability, persons with mental disabilities, and the possibility that any individual may become mentally disabled—ignore the most important question of all: Why do we feel the way we do about people with mental disabilities? (Perlin, 2003e). Just as importantly, perhaps *more* importantly, we rarely even ask this question (Perlin, 1999). Have we learned anything in the 20 years since Carmel Rogers wrote, "Because the preserve of psychiatry is populated by 'the mad' and 'the loonies,' we do not really want to look at it too closely—it is too frightening and maybe contaminated" (1994, p. 208).

The use of stereotypes perpetuates the stigma that is at the root of sanism. And, in many ways sanism is more pernicious than other stereotypes because it is engaged in by many who would (appropriately) take quick umbrage at the use of stereotypes about other marginalized groups (Perlin, 1992b, p. 373). Because we unthinkingly consider persons with mental disabilities to be "less than human," we can comfortably take refuge in the reductive stereotypes of stigmatizing sanism. What is especially troubling here is that these stereotypes are employed not solely by lay people (and the popular press) but by judges and the very lawyers assigned to represent this population (Perlin, 2000d). Sanist lawyers trivialize both their clients' problems and the importance of any eventual solution to these problems, and implicitly and explicitly question their clients' competence and credibility, a move that significantly impairs the lawyers' advocacy efforts (Perlin, 2009d; Perlin and Lynch, 2016).). The pervasiveness of sanism infects all aspects of the legal process and of life. We cannot make any meaningful progress in coping with stigmatic stereotypes until we come to grips with this. By engaging in stigmatic stereotypes, we rob persons with mental disabilities of their dignity, often shaming and humiliating them in the process (Perlin and Weinstein, 2014).

Significantly, we tend to ignore, subordinate, or trivialize behavioral research in this area, especially when acknowledging that such research would be cognitively dissonant with our intuitive (albeit empirically flawed) views. (On the dangers of teleological decision making in this context, see Perlin, 2008a, pp. 599–600). "'Sensational' media portrayals of mental illness" (Winick, 2009, p. 847; see also, Cutcliffe and Hannigan, 2001) exacerbate the underlying tensions. Society believes that "mental illness can be easily identified by lay persons and matches up closely to popular media depictions" (Perlin, 1992b, p. 395; see also, Berlin and Malin, 1991; Hyler et al., 1991). It is commonly assumed that persons with mental illness cannot be trusted (Johnston, 2011, p. 536). Common stereotypes about people with mental illness include the beliefs that they are "dangerous, unreliable, lazy, responsible for their illness or otherwise blameworthy, faking or exaggerating their condition, or childlike and in need of supervision or care" (Emens, 2006, p. 416–17).

Sanism may manifest in a general tendency to distrust decisions of persons with mental illness and in assumptions that "individuals who exercise their right to counsel are 'crazy' and incapable of sufficiently autonomous decision making" (Johnston, 2011, p. 536). Sanism most commonly manifests itself in the belief that, "despite the lack of supporting evidence, people with mental disabilities are inherently incompetent, deviant, dangerous, or violent" (Pannell, 2011, pp. 1181–82). Evidence that, by way of example, persons with mental illness document information in advance directive documents that are "consistent with community practice standards" is counterintuitive to a sanist public (Elbogen et al., 2007, p. 283).

Social science research confirms that mental illness is "one of the most—if not the most—stigmatized of social conditions" (Stefan, 2000, p. 5). Historically, individuals with psycho-social disabilities "have been among the most excluded members of society . . . Research firmly establishes that people with mental disabilities are subjected to greater prejudice than are people with physical disabilities" (Waterstone and Stein, 2008, pp. 1363–64). Mental disabilities are the most negatively perceived of all disabilities (Perlin, 1993–94, p. 26).

Our sanist myths, based on stereotypes, are the result of rigid categorization and overgeneralization; they function psychologically to "localize our anxiety, to prove to ourselves that what we fear does not lie within" (Gilman, 1985, p. 240). Consider the basic sanist myths that have developed over the years:

1. Mentally ill individuals are "different," and, perhaps, less than human. They are erratic, deviant, morally weak, sexually uncontrollable, emotionally unstable, superstitious, lazy, and ignorant and demonstrate a primitive morality. They lack the capacity to show love or affection. They smell different from "normal" individuals and are somehow worth less.
2. Most mentally ill individuals are dangerous and frightening. They are invariably more dangerous than nonmentally ill persons, and such dangerousness is easily and accurately identified by experts. At best, people with mental disabilities are simple and content, like children. Either *parens patriae* or police power supply a rationale for the institutionalization of all such individuals.
3. Mentally ill individuals are presumptively incompetent to participate in "normal" activities, to make autonomous decisions about their lives (especially in areas involving medical care), and to participate in the political arena.
4. If a person in treatment for mental illness declines to take prescribed antipsychotic medication, that decision is an excellent predictor of (a) future dangerousness and (b) need for involuntary institutionalization.
5. Mental illness can easily be identified by lay persons and matches up closely to popular media depictions. It comports with our common sense notion of crazy behavior.
6. It is, and should be, socially acceptable to use pejorative labels to describe and single out people who are mentally ill; this singling out is not problematic in the way that the use of pejorative labels to describe women, blacks, Jews, or gays and lesbians might be.
7. Mentally ill individuals should be segregated in large, distant institutions because their presence threatens the economic and social stability of residential communities.
8. The mentally disabled person charged with a crime is presumptively the most dangerous potential offender, as well as the most morally repugnant one. The insanity defense is used frequently and improperly as a way for such individuals to beat the rap; insanity tests are

so lenient that virtually any mentally ill offender gets a free ticket through which to evade any and all criminal and personal responsibility. The insanity defense should be considered only when the mentally ill person demonstrates objective evidence of mental illness.
9. Mentally disabled individuals simply don't try hard enough. They give in too easily to their basest instincts and do not exercise appropriate self-restraint.
10. If do-gooder, activist attorneys had not meddled in the lives of people with mental disabilities, such individuals would be where they belong (in institutions), and all of us would be better off. In fact, there's no reason for courts to involve themselves in all mental disability cases (Perlin, 1992b, pp. 393–97).

One might optimistically expect, though, that this gloomy picture should be subject to change because of a renewed interest in the integration of social science and law. One might also expect that litigation and legislation in these areas would draw on social science data in attempting to refute these myths.

But this has not happened. Attempts to place mental disability law jurisprudence in context results in confrontation with a discordant reality: Social science is rarely a coherent influence on mental disability law doctrine (e.g., English, 1988; Perlin, 1989–90). Rather, the legal system selectively and teleologically (either accepts or rejects social science data depending on whether or not the use of that data meets the a priori needs of the legal system, Perlin, 1994, p. 261; Applebaum, 1987, pp. 341–42). In other words, social science data is privileged when it supports the conclusion the fact finder wishes to reach, but it is subordinated when it questions such a conclusion. Just as we tend to ignore, subordinate, or trivialize behavioral research in this area, especially when acknowledging that such research would be cognitively dissonant with our intuitive albeit empirically flawed views, we give such evidence too *much* weight when it reinforces our previously internalized positions (Birgden et al., 2008). As John LaFond and Mary Durham have underscored:

> Judges' refusals to consider the meaning and realities of mental illness cause them to act in what appears, at first blush, to be contradictory and inconsistent ways and, teleologically, to privilege (where that privileging serves what they perceive as a socially-beneficial value) and subordinate (where that subordination serves what they perceive as a similar value) evidence of mental illness. (1992, p. 156)

These ends are sanist (see, generally, Perlin, 1992b; Winick, 1996). In other words, decision making in mental disability law cases is inspired by (and reflects) the same kinds of irrational, unconscious, bias-driven stereotypes and prejudices that are exhibited in racist, sexist, homophobic, and religiously and ethnically bigoted decision making (Perlin, 1992b, pp. 3773–77; see, generally, Perlin and Dorfman, 1993). Sanist decision making infects all branches of mental disability law and distorts mental disability jurisprudence. Judges regularly refer to expert witnesses testifying on behalf of persons with mental disabilities as “whores” or “hired guns” (Mossman, 1999; Edens et al., 2012).[2] Paradoxically, while sanist decisions are frequently justified as being therapeutically based, sanism customarily results in antitherapeutic outcomes (Wexler, 1992).[3]

Judges are not immune from sanism. “[E]mbedded in the cultural presuppositions that engulf us all” (D’Amato, 1991, p. 332), judges also take deeper refuge in heuristic thinking and flawed, nonreflective “ordinary common sense.” They reflect and project the conventional morality of the community, and judicial decisions in all areas of civil and criminal mental disability law continue to reflect and perpetuate sanist stereotypes (Perlin, 1992b, pp. 400–404). This applies to all areas of mental disability law (on involuntary civil commitment, see Perlin, 1993; on the criminal trial process, see Perlin, 2004; Parry, 2005, with specific reference to the death penalty; on the operation of the child welfare system, see Glennon, 2003; on guardianship, see Dlugacz and Wimmer, 2011; on family protection, see Champine, 2003; on the insanity defense, see Bredemeier, 2000; on health care, see Rosenberg, 2009; on medical privacy, see Rosenberg, 2013).

Judges are not the only sanist actors. Professor Jude Pannell noted in the context of child protection issues: “On a system-wide level, some caseworkers fail to make the necessary efforts to preserve and reunite families because sanism leads them to believe any efforts they make are futile and mentally disabled parents cannot become capable of parenting” (2011, p. 1883). Beyond this, lawyers, legislators, jurors, and witnesses (both lay and expert) all exhibit sanist traits and characteristics (Perlin, 1992b, pp. 398–406; Gould and Perlin, 2000, p. 345, n. 35). Sanist myths exert especially great power over lawyers who represent persons with mental disabilities (Perlin, 2003e, p. 684). Until system “players” confront the ways that sanist biases (selectively incorporating or misincorporating social science data) inspire such pretextual decision making, mental disability jurisprudence will remain incoherent. Behaviorists, social scientists, and legal scholars must begin to develop research agendas so as to (1) determine and assess the ultimate impact of sanism, (2) better understand how social science data is manipulated to serve sanist ends, and (3) formulate normative and instrumental strategies that can be used to rebut sanist pretextuality in the legal system. Practicing lawyers need to articulate the existence and dominance of sanism and of pretextual legal behavior in their briefs and oral arguments so as to sensitize judges to the underlying issues.

As we will discuss extensively in the remainder of this book, sanism permeates all of law and social policy as it relates to the question of the sexuality rights of persons with disabilities, and it buttresses our "tradition of palpable discomfort when it comes to even thinking about patient sexuality" (Perlin, 2008b, p. 508). Professor Eric Wright and his colleagues have written carefully and thoughtfully about how the stigma of mental illness (leading to social rejection) increases the sense of "sexual isolation" suffered by persons with mental illness (Wright et al., 2007). The sexual relationships of persons with serious mental illness have been characterized as "short-term, episodic . . . or 'chaotic.'" (Dickerson et al., 2004). Researchers have concluded that the stigma of such mental illness can lead to "individual and structural sexual discrimination" (Wright et al., 2007, p. 92).

As the authors have written elsewhere, "sanist judicial decisions in cases involving persons with mental disabilities in the full range of sexuality matters rob such individuals of the basic dignity to which they are entitled" (Perlin and Lynch, 2014, p. 273). The policies that presume that psychiatric patients—by reason of their institutionalization—cannot enter into autonomous decision making in the areas of sexual choice are sanist at base (Perlin, 1997a). Articulating these biases and demonstrating the malignancy of "the corrosive impact of sanism on the legal process" (Perlin, 2004, p. 254) is the heart of this book.

B. Pretextuality

Sanist attitudes also lead to pretextual decisions (see generally, Perlin, 2013a). "Pretextuality" means that courts regularly accept (either implicitly or explicitly) testimonial dishonesty, countenance liberty deprivations in disingenuous ways that bear little or no relationship to case law or to statutes, and engage similarly in dishonest (and frequently meretricious) decision making, specifically where witnesses, especially expert witnesses, show a "high propensity to purposely distort their testimony in order to achieve desired ends" (Perlin, 1991b, p. 133). This pretextuality infects the civil commitment system (Freckelton, 2003; Grundell, 2005), the sex offender commitment system (Perlin, 1998a; Miller, 2010), right to refuse treatment decision making (Perlin and Dorfman, 1996), the forensic mental health system (Perlin, 1993), incompetency and insanity determinations (Perlin, 1997b; Perlin, 1993; Perlin, 2004), as well as a significant amount of police testimony in cases involving Fourth Amendment challenges to searches (see Sevilla, 1974, p. 840). This pretextuality is poisonous; it infects all participants in the judicial system, breeds cynicism and disrespect for the law, demeans participants, and reinforces shoddy lawyering, blasé judging, and, at times, perjurious and/or corrupt testifying (Perlin, 2003c, p. 25). Such pretextuality also leads to anti-therapeutic law (Yates, 1994).

Pretextual devices such as condoning perjured testimony, distorting appellate readings of trial testimony, subordinating statistically significant social science data, and enacting purportedly prophylactic civil rights laws that have little or no "real world" impact dominate the mental disability law landscape (Perlin, 2000d, p. 67). Judges in mental disability law cases often take relevant literature out of context (Faigman, 1991), misconstrue the data or evidence being offered (id., see also, Brooks, 2010, p. 299: ("The use of structured clinical decision-making can help eliminate pretextual assessments of danger"), and/or read such data selectively (Katz, 1998), and/or inconsistently (Hafemeister and Melton, 1987; Sperlich, 1985; Haney, 1982). Other times, courts choose to flatly reject this data or ignore its existence (see, e.g., *Barefoot v. Estelle*, 1983, discussed in this context in Perlin, 2013b; *Parham v. J.R.*, 1979, discussed in this context in Faigman, 1991, and in Perlin, 1981).

In other circumstances, courts simply "rewrite" factual records so as to avoid having to deal with social science data that is cognitively dissonant with their view of how the world "ought to be" (on "empirical pretextuality," see Perlin, 1993, p. 635). The US Supreme Court has had a special propensity in mental health cases to base opinions on "simply unsupportable" factual assumptions (Morse, 1987, p. 382, n. 64). As Gail Perry and Gary Melton noted in their analysis of that Court's decision in *Parham v. J.R.* (1979), countenancing *less* due process in cases involving the civil commitment of *juveniles* than in cases involving the commitment of *adults:*

> The *Parham* case is an example of the Supreme Court's taking advantage of the free rein on social facts to promulgate a dozen or so of its own by employing one tentacle of the judicial notice doctrine. The Court's opinion is filled with social facts of questionable veracity, accompanied by the authority to propel these facts into subsequent case law and, therefore, a spiral of less than rational legal policy making. (1984, p. 685)

Even when courts do acknowledge the existence and possible validity of studies that take a contrary position from their decisions, this acknowledgment is frequently little more than mere "lip service." (See opinion of Justice Stevens, concurring in part and dissenting in part, in *Washington v. Harper,* 1990, on prisoners limited liberty interest in right to refuse forcible administration of antipsychotic medications, suggesting that the majority's acknowledgment of the common side effects of such medications was largely illusory, id., pp. 247–49.) Although some courts have examined decision making for evidence of pretextuality, that is done—mostly but not exclusively (see, e.g., *Monaco v. Hogan,* 2008, p. 351, n. 32, rejecting plaintiffs' arguments that pretextuality of some certifications of dangerousness supported a conclusion that the psychiatrists in question acted with deliberate indifference)—in the context of employment questions (e.g., *Milanes v. Holder*, 2011; *Rosado v. Am. Airlines*, 2010; *Drwal v. Borough of West View, Pennsylvania*, 2009).

Other authors have noted the pretextual bases of legal decisions related to other aspects of sexuality and sexual behavior. For example, writing about sex offender law, Professor Thomas Zander has argued that "diagnosis should never be a pretext for social control" (2008, p. 468). Professors James Vaught and Margaret Henning have shown how, in rape prosecutions, sexual fantasies were traditionally seen as characteristic of "unchaste women" (1992, p. 903). Professors Martha Chamallas and Linda Kerber have critiqued the pretextual nature of case law that incorporates the double standard of sexual morality in dealing with "the tortious consequences of adultery" (1990, p. 818, critiquing). Professor Nancy Ehrenreich has critiqued the pretextual nature of sexual harassment decisions for reinforcing a "boys will be boys" ideology (1990, p. 1209). Professor Lawrence Friedman has critiqued the pretextual nature of prostitution control law (1984, pp. 21–23). And Thomas Griffen has criticized zoning laws as "pretext[s]" for suppressing adult entertainment (1988, p. 1405).

Consider also court decisions in other areas related to sexual behavior: a plaintiff's mode of dress, lifestyle, and "expressed sexual fantasies" were all held to be admissible evidence in sexual harassment claim (*Meritor Savings Bank v. Vinson*, 1986, pp. 68–69). Other courts have required an overt evidentiary showing that workplace sexual harassment affected an employee's "psychological well-being" (*Henson v. City of Dundee,* 1982). Further, in *Rabidue v. Osceola Refining Co*., the Michigan Court of Appeals refused to find the work environment hostile even though it was shown that the workplace contained posters of naked and partially dressed women and male employees customarily called women derogatory, sexualized names. The court in *Rabidue* considered the fact that the plaintiff was "a capable, independent, ambitious, aggressive, intractable, and opinionated woman," and reasoned that such an individual would not be affected by the harassment of the defendants (*Rabidue v. Osceola Refining Co*., 1986, pp. 612–615). Although the impact of this case was ultimately diminished when *Rabidue* was abrogated by a United States Supreme Court decision that held that, to be actionable as "abusive work environment" harassment, conduct need not seriously affect an employee's psychological well being or lead the employee to suffer injury (*Harris v. Forklift Systems,* 1993), the fact that a federal court of appeals reasoned in this manner less than 30 years ago remains relevant.

There is no question that sanist myths lead to pretextual decision making. As Professor Susan Stefan has perceptively noted, courts routinely find mentally disabled women incompetent to engage in sexual intercourse (i.e., to lack sufficient competence to engage knowingly and voluntarily in such behavior), but just as routinely find such individuals competent to consent to give their children up for adoption (Stefan, 1993, p. 805). In one startling case, a court made both of these findings simultaneously about the same woman (*State v. Soura*, 1990, pp. 113–15).

As we will discuss more extensively subsequently, other pretextual decision making is regularly present in cases involving criminal prosecutions of men charged with having sex with mentally disabled women (Stefan, 1993, p. 796). Professor Stefan's analysis of these cases suggests that courts regularly employ a series of pretexts as to the woman's capacity to consent in cases where, otherwise, a conviction might not be sustainable under traditional rape law standards (id., pp. 796–99). If there is a question concerning whether a particular rape victim "consented," a judicial finding that she lacked mental capacity makes the consent inquiry irrelevant, thus intuitively making a conviction far more likely.

In other contexts, parents with mental disabilities can lose custody of their children because of behavior—such as having a "bad attitude" or being sexually promiscuous—that would rarely (if ever) be invoked if displayed by nondisabled parents (Stefan, 1989, p. 448, discussing *In re J. L. P.*, 1982, pp. 1251–53). In one parental rights termination case, expert testimony that persons with disabilities "cannot show love and affection as well as can persons of normal intelligence" was relied upon to support termination findings (see *In re McDonald,* 1972, p. 450).

In short, as in other areas of mental disability law, the pretexts of trial testimony and judicial decision making, premised on sanist myths, pervade all judicial decision making in this area. In this book, we will demonstrate the pretextuality of the law's regulation of the sexual autonomy of persons with mental disabilities, especially those institutionalized because of such disabilities.

C. Heuristics

"Heuristics" (see, generally, Perlin, 2013a; Cucolo and Perlin, 2013) is a cognitive psychology construct that refers to the implicit thinking devices that individuals use to simplify complex, information-processing tasks (Perlin, 1990b; Saks and Kidd, 1980–81; Scott, 1986; see, generally, Kahneman et al., 1982; Brehm and Brehm, 1981; Nisbett and Ross, 1980). The use of such constructs frequently leads to distorted and systematically erroneous decisions (Perlin, 1990a; Saks and Kidd, 1980–81; Carroll and Payne, 1976; Coverdale et al., 2000) "through ignoring or misusing rationally useful information" (Perlin, 1992a, p. 57, n. 115; Carroll and Payne, 1976, p. 21; Perlin, 1997b, p. 1417; Mossman, 1995, p. 100, n. 32).

One single vivid, memorable case overwhelms mountains of abstract, colorless data upon which rational choices would be better made (Perlin, 2009c, p. 82). Former President Reagan's famous "welfare queen" anecdote is a textbook example of heuristic behavior (Perlin, 1990b, p. 16, n. 59). Empirical studies reveal jurors' susceptibility to the use of these devices (Koehler and Shaviro, 1990; Torrey, 1991; Lieberman and Krauss, 2009); by way of example, valid and reliable research teaches us that jurors' preexisting attitudes toward insanity defense are the strongest predictor of individual verdicts (Roberts and Golding, 1991).

Similarly, legal scholars are notoriously slow to understand the way that the use of these devices affects the way individuals think (Tomlinson, 1995). The use of heuristics "allows us to willfully blind ourselves to the 'gray areas' of human behavior" (Perlin, 2003c, p. 27) and predispose "people to beliefs that accord with, or are heavily influenced by, their prior experiences" (Covey, 2009, p. 1381).

Elsewhere, one of the coauthors (MLP) has argued:

> Testimony [in mental disability law cases] is further warped by a heuristic bias. Expert witnesses—like the rest of us—succumb to the seductive allure of simplifying cognitive devices in their thinking and employ such heuristic gambits as the vividness effect or attribution theory in their testimony. This testimony is then weighed and evaluated by frequently sanist fact-finders. Judges and jurors, both consciously and unconsciously, often rely on reductionist, prejudice-driven stereotypes in their decision-making, thus subordinating statutory and case law standards as well as the legitimate interests of the mentally disabled persons who are the subject of the litigation. Judges' predispositions to employ the same sorts of heuristics as do expert witnesses further contaminate the process. (Perlin, 1993, pp. 602–3; see also, generally, Bursztajn et al., 1988).

Thus, through the "vividness" heuristic, a single vivid, memorable case overwhelms mountains of abstract, colorless data upon which rational choices should be made (Doob and Roberts, 1984; Diamond and Stalans, 1989; Rosenhan, 1984). Through the "availability" heuristic, we judge the probability or frequency of an event based upon the ease with which we recall it (Perlin, 1997b, p. 1417). Through the "typification" heuristic, we characterize a current experience via reference to past stereotypic behavior (Van Zandt, 1987; Perlin, 1991c, p. 125).

Through the "attribution" heuristic, we interpret a wide variety of additional information to reinforce preexisting stereotypes (Khoshbin and Khoshbin, 2007, p. 182; Kelley, 1973). Through the heuristic of the "hindsight bias," we exaggerate how easily we could have predicted an event beforehand (Wexler and Schopp, 1989; Arkes, 1989; Dawson et al., 1988; Fischhoff, 1975). Through the heuristic of "outcome bias," we base our evaluation of a decision on our evaluation of an outcome (Baron and Hershey, 1988; Arkes, 1989; Tversky and Kahneman, 1982). Through the "representative heuristic," we extrapolate overconfidently based upon a small sample size of which we happen to be aware (Tversky and Kahneman, 1982). Through the heuristic of "confirmation bias," people tend to favor "information that confirms their theory over disconfirming information" (Burke, 2006). In some ways, the most pernicious is the vividness effect, as it teaches us that "when decisionmakers are in the thrall of a highly salient event, that event will so dominate their thinking that they will make aggregate decisions that are overdependent on the particular event and that overestimate the representativeness of that event within some larger array of events" (Schauer, 2006, p. 895, discussed in this context in Perlin, 2008b, p. 492, n. 46).

Research confirms that heuristic thinking dominates all aspects of the mental disability law process whether the question is one of involuntary civil commitment law (Hiday and Smith, 1987; Bagby and Atkinson, 1988), violence assessment (Murray and Thomson, 2010), sex offender decision making (Cucolo and Perlin, 2013), medication refusal (Perlin, 1991c), diagnostic accuracy (Dawes et al., 1989; Faust, 1989), the insanity defense (Perlin, 1995), the death penalty (Perlin, 1994), competency to stand trial procedures (Perlin, 1993), the relationship between homelessness and deinstitutionalization (Perlin, 1991a), the use of neuroimaging evidence in the criminal trial process (Perlin, 2009b), or the scope of a therapist's duty to protect a third party from a tortious act by the therapist's patient or client (the so-called *Tarasoff* obligation, see Perlin, 2006).

As will be explored subsequently in this book, heuristic thinking dominates our policies as they relate to sexuality and disability. Recall our earlier discussion (see Chapter 1, p. 9) about the ways we simultaneously "infantilize the sexual urges, desires, and needs" of persons with mental disabilities, and regard them as "possessing an animalistic hypersexuality," which warrants the imposition of special protections and limitations on their sexual behavior to stop them from acting on their "primitive" urges (see, e.g., Perlin and Lynch, 2014, p. 260). It is our use of heuristic thinking devices that justifies this irrational behavior and that deprives this population of its basic human and civil rights.

D. *"Ordinary Common Sense"*

"Ordinary common sense" (OCS; see, generally, Perlin, 2013a) is a "powerful unconscious animator of legal decision making" (Perlin, 2003c, p. 25). It is a psychological construct that reflects the level of the disparity between perception and reality that regularly pervades the judiciary in deciding cases involving individuals with mental disabilities (Perlin, 1997b, p. 1417). OCS is self-referential and nonreflective: "I see it that way, therefore everyone sees it that way; I see it that way, therefore that's the way it is" (Perlin, 2009b, p. *24, n. 84). It is exemplified by the attitude of "What I know is 'self evident'; it is 'what everybody knows'" (Sherwin, 1988, p. 737) and is supported by our reliance on a series of heuristics-cognitive-simplifying devices that distort our abilities to rationally consider information (Perlin, 2000a). It is absolutely essential for any mental disability law course (or sequence of courses) to consider the significance of OCS (Perlin, 2010a).

The positions frequently taken by former Chief Justice Rehnquist and Justices Scalia, Alito, and Thomas in criminal procedure cases—especially those involving defendants with mental disabilities—best highlight the power of OCS as an unconscious animator of legal decision making (see, e.g., Perlin, 2003b, pp. 329–30, discussing, in this context, Justice Scalia's dissent in *Atkins v. Virginia*, 2002: death penalty unconstitutional as applied to persons with mental retardation; see also, Perlin and Cucolo, 2015, § 17-4.2.2, discussing, in this context, Justice Alito's dissent in *Hall v. Florida,* 2014). Such positions frequently demonstrate a total lack of awareness of the underlying psychological issues and focus on such superficial issues as whether a putatively mentally disabled criminal defendant bears a "normal appearance" (see, e.g., *State Farm Fire & Cas. Ltd. v. Wicka*, 1991, p. 327, *s*tating that both law and society are always more skeptical about a putatively mentally ill person who has a "normal appearance" or "doesn't look sick").

These are not the first jurists to exhibit this sort of closed-mindedness. Trial judges will typically say, "he (the defendant) doesn't look sick to me," or, even more revealingly, "he is as healthy as you or me" (Perlin, 1975, p. 147; Covey, 2009, p. 1381). In short, advocates of OCS believe that simply by using their OCS, jurists can determine whether criminal defendants conform to "popular images of 'craziness'" (Lasswell, 1974, p. xi). If they do not, the notion of a handicapping mental disability condition is flatly, and unthinkingly, rejected (id.). Such views—reflecting a false OCS—are made even more pernicious by the fact that we "believe most easily what [we] most fear and most desire" (Barton, 1996, p. 1249). Thus, OCS presupposes two "self-evident" truths: "First, everyone knows how to assess an individual's behavior. Second, everyone knows when to blame someone for doing wrong" (Sherwin, 1988, p. 738).

Professor Jennifer Mnookin captures this perfectly in a recent article about forensic science in which she discusses a colloquy with a seatmate on a plane ride:

> On a recent flight, the person next to me on the crowded airplane began to chat with me. When I told her about what I researched and studied, she looked at me with a big grin. "I LOVE forensic science," she said. "I watch CSI whenever I can. They can do such amazing things. It's all so high tech—and incredibly accurate! It's almost like magic, isn't it?" She leaned in a bit closer and looked at me intently. "Tell me, is it like that in real life?"
>
> I looked at her for a moment before answering. I felt a bit like the older child on the playground about to reveal to her younger friend that Santa Claus doesn't really exist. I shook my head. "No, I wouldn't say that CSI's depiction is entirely realistic. In the real world, forensic science isn't nearly so glossy. It isn't nearly so speedy. And most important, it isn't nearly so foolproof, either."
>
> "Really? That's too bad," she told me. She looked at me directly for a brief moment, shook her head, and then looked away. "Well, to tell you the truth, I think I'd rather just keep believing in the television version." Figuring that reality was not going to be any match for CSI, I shrugged, and went back to the book I was reading. (Mnookin, 2010, p. 1209)

Consider our insanity defense jurisprudence (see, generally, Perlin, 1995). Not only is it prereflexive and self-evident, it is also susceptible to precisely the type of idiosyncratic, reactive decision making that has traditionally typified insanity defense decision making. Paradoxically, the insanity defense is necessary precisely because it rebuts "common-sense everyday inferences about the meaning of conduct" (Sendor, 1986, p. 1372). OCS dominates our attitudes toward law enforcement in general (Flagel and Gendreau, 2008). Empirical investigations corroborate the inappropriate application of OCS to insanity defense decision making (Daftary-Kapur et al., 2011). Judges "unconsciously express public feelings . . . reflect[ing] community attitudes and biases because they are 'close' to the community" (Arens and Susman, 1966, p. 34, n. 23; see also, Bloechl et al., 2007). Virtually no members of the public can actually articulate what the substantive insanity defense test is (Hans and Slater, 1984). The public is seriously misinformed about both the "extensiveness and consequences" of an insanity defense plea (Hans, 1986). By way of example, jurors construct mental disability as an "all or nothing" concept and, when forced to choose a substantive insanity test, select the eighteenth century, pre-M'Naghten, "wild beast" test[4] as the one that most comports with their "ordinary common sense" concepts of justice (Roberts & Golding, 1991; Perlin, 2009c, p. 899).

This is far from the only area of the law contaminated by OCS (see, generally, Perlin and Douard, 2008–9). It is used regularly in considerations of sex offender law (Birgden, 2004), the inadequacy of advocacy systems (Costello, 1996), outpatient commitment (Perlin, 2003d), institutional rights law (Perlin et al., 1995), right to refuse treatment law (id.), or health care/hospital law (Hall, 2002). OCS also perpetuates false beliefs in police and criminal psychology (Aamodt, 2008; Lurigio, 2011). So it is no wonder that OCS can infect any consideration of issues of patients' sexual autonomy. Writing in a very different context, about attitudes toward mothers who commit neonaticide, one of the authors (MLP) said this:

> Cases, especially those subject to saturation publicity, serve as "projective tests" that reflect our massive societal ambivalence about motherhood, sexuality, social norms, and interpersonal relationships, and our shock when individuals act in a way "wholly alien" from our OCS, especially when the defendant presents herself as a "nice, middle class [Caucasian, implied] girl." (Perlin, 2003c, p. 10; see also, Steelman, 2002; Lusk, 2002; Macfarlane, 1998)

Certainly, as we will discuss extensively below, the idea that persons with disabilities are sexually active, have sexual desires, and want to continue to be sexually active is profoundly dissonant from much of society's OCS on this topic. Writing about this topic, Andreas Dimopoulos carefully discussed the "social stereotype for persons with intellectual disability that they should not be having sex, that they should be asexual" (2012, p. 9). This stereotype is just one example of OCS in this area that is radically different from reality.

Sanism, pretextuality, OCS, and heuristics are not only dangerous ways of ensuring that individuals with mental disabilities are not given the full range of rights and privileges that nondisabled individuals may take for granted, but also can be combined and used in tandem to serve as a paternalistic "guard" for individuals with disabilities. These concepts, on their own or together, also serve as public reassurance, letting society know that these individuals, viewed as the "Other," will continue to be easily identified as such and treated in a manner related to their status as outsiders. As we will discuss further, when the already-taboo concepts of sexuality and autonomy are layered on, individuals with disabilities will be subject to even greater scrutiny, paternalism, and denial of rights than in many other contexts.

3

Perspectives from the Law

I. Patients' Constitutional Rights: The Right to Sexual Interaction

Remarkably little attention has been paid to one of the most basic and fundamental of all civil and human rights: the right to sexual interaction (see Perlin and Cucolo, 2015, § 9-5.1). Any consideration of this issue must start with *Wyatt v. Stickney* (1972) and *Wyatt v. Aderholt* (1974), the most important institutional rights case litigated in the history of domestic mental disability law (see Perlin and Cucolo, 2015, § 7-3.1.5), and the first broad-based law reform case granting a right to treatment to institutionalized psychiatric patients (see id., §§ 7-3.1 to 7-3.1.4), establishing an expansive right to treatment on behalf of persons institutionalized by reason of both mental illness and intellectual disabilities (see id., § 7-3.1). *Wyatt* spawned copycat litigation in multiple federal district courts and state supreme courts; (see id., § 7-3.1.8). It led directly to the creation of Patients' Bills of Rights in most states (Perlin, 2011a; Perlin, 2008b), and it inspired the creation of the Developmental Disabilities Assistance and Bill of Rights Act (Herr, 1989–90), the Mental Health Systems Act Bill of Rights (Tovino, 2007), and the federally funded Protection and Advocacy System (Herr, 1989–90).

The treatment standards established in *Wyatt* the first broad-based law reform case granting a right to treatment to institutionalized psychiatric patients (Perlin and Cucolo, 2015, § 7-3.1.1), guaranteed such individuals the right to reasonable interaction with members of the opposite sex (*Wyatt*, 1972, p. 381). Of the many states that adopted the Wyatt standards as bases of their Patients' Bills of Rights, however, only four adopted this portion of the standards (Lyon et al., 1982). There has also been no follow-up litigation based upon any of the statutes that do provide for this right, and only a scattering of cases has been litigated anywhere that has sought to vindicate this right (see, e.g., *Gary W. v. Louisiana,* 1976, pp. 1228–29; *Davis v. Watkins,* 1974, p. 1206, both endorsing the *Wyatt* methodology;

but see id., p. 1208: "Patients shall be provided counseling or other treatment for homosexuality"). Few of the reported cases harmonize previous decisions or seek to create a comprehensive jurisprudence in this area. (C*ompare V.H. v. K.E.J. [In re Estate of K.E.J.*], 2008, holding that neither the right to bear children nor the right of personal inviolability is absolute in the case of an individual who has been adjudicated as incompetent, to *Conservatorship of Angela D*., 1999, finding that supervision of conservatee was not available as less invasive alternative form of contraception was supported by evidence). There is also no mention of this right in any contemporaneous federal civil rights legislation (Perlin, 1997a).

All of this leads, logically, to the next question: Why has this area—one that deals with the most personal of rights—not been the subject of greater scrutiny, either in court decrees, or even in substantial legal scholarly writings? This is especially ironic in that we acknowledge the significance of sexual autonomy in related areas of *physical disability* law, but we ignore it here. The law, by way of example, acknowledges that sexual desire is a sufficiently important personal trait so that its diminution must be weighed into the formulation of a medication refusal policy. "Yet the law simultaneously denies the power and importance of sexual desire with respect to hospital ward life" (Perlin, 1993–94, p. 531). There *has been* important attention paid to this issue in nursing and psychiatric literature (see, e.g., Torkelson and Dobal, 1999; Quinn and Happell, 2015a, 2015b; Dobal and Torkelson, 2004; McCann, 2003; Stevenson, 2004), but there has been virtually no carryover to the question of the legal implications of our policies, or the lack of such policies (see Bowers et al., 2014, p. 271: "The sexual behaviour of acute psychiatric inpatients has largely been ignored both by hospital policies and by the academic literature").

There has, however, been extensive follow-up litigation to implement the *Wyatt* order (see Perlin, 2011a). In a comprehensive opinion, a federal district court reconsidered the extent to which defendants had complied with each of the standards in the original litigation in *Wyatt*, granting partial release from certain provisions of the decree with which defendants had complied, but denying release from others (*Wyatt by and through Rawlins v. Rogers,* 1997). On the question of medical care, the court found that defendants were in compliance and thus released the state from the terms of the decree (id., p. 1395). However, on the question of sex, it noted, somewhat elliptically, in language that has never been cited in another reported case in the 18 subsequent years:

> The only reservation the court has . . . is the failure of the defendants to provide condoms to patients who are HIV-positive and known to be sexually active. The court hopes that the defendants have addressed this problem. (id.).

Probably the most interesting case in this area of the law is *Foy v. Greenblott (*1983). There, an institutionalized patient and her infant child (conceived and born while the mother was a patient in a locked psychiatric ward) sued the mother's treating doctor for his failure to either maintain proper supervision over her so as to prevent her from having sex or to provide her with contraceptive devices and/or sexual counseling (id., p. 87).

The court rejected the plaintiffs' claims of improper supervision, finding that institutionalized patients had a right to engage in voluntary sexual relations as an aspect of either the "least restrictive environment" or "reasonably non-restrictive confinement conditions," and that that right included "suitable opportunities for the patient's interactions with members of the opposite sex" (id., p. 90, n. 2). On the other hand, it did characterize defendants' failure to provide plaintiff with contraceptive devices and counseling as a deprivation of her right to reproductive choice (id., p. 90). It also rejected a claim for "wrongful birth" by her infant child, concluding, "Our society has repudiated the proposition that mental patients will necessarily beget unhealthy, inferior or otherwise undesirable children if permitted to reproduce" *(*id., p. 93).

The general lack of litigation in this area of the law may appear anomalous. Self-evidently, institutionalized persons do not lose their sexuality when they lose their liberty. (Stefan, 1993; Dickerson et al., 2004; Wright et al., 2007). Yet, most states do not recognize their patients' right to personal, intimate relationships. At least one court has recognized how anomalous this regulation is. In *People v. Dean* (2010) a case in which a state appellate court reversed a statutory rape conviction in a case involving a defendant who had consensual sex with a peer developmentally disabled woman (whom he had known for 10 years), the court reasoned "that defendant's conviction, if upheld, would make it likely that virtually anyone who engaged in sex with her would be committing a crime" (id., p. 598).

Often, the right to sexual interaction depends on the whim of line-level staff or on whether such interaction is seen as an aspect of an individual patient's treatment plan (Stefan, 1989). It has even been suggested that "sexual activities between psychiatric inpatients should be strictly prohibited, and when it occurs patients should be isolated . . . and tranquilized if necessary" (Binder, 1985, p. 125). One hospital's guidelines stated, "If you develop a relationship with another patient, staff will get together with you to help decide whether this relationship is beneficial or detrimental to you" (Keitner and Grof, 1981, p. 193). Hospital staff is often hostile to the idea that patients are sexually active in any way (e.g., Sheehan, 1983; Buckley and Hyde, 1997; Ford et al., 2003); patients in one sex education group confided that asking nurses for condoms was "embarrassing because staff frowned on sexual activity among patients" (Welch et al., 1991, p. 855). In one case—decided *before Wyatt*—individuals released from institutionalization were ordered to not marry as a prerequisite to release (Ellis, 1992). For many years, consent to sterilization was a necessary consent to institutional release (Oberman, 2010; Seltzer, 1998), and this practice continued through, at least, the 1960s (see, e.g., *In re Cavitt*, 1968).

Although now more enlightened institutional mental health professionals and behaviorists recognize that patients "are and wish to be sexually active" (Welch et al., 1991; Abramson et al., 1988), and that sexual freedom has therapeutic value (Binder, 1985), and while others call attention to our societal obligation to provide family planning assistance to women institutionalized in psychiatric hospitals (Abernethy et al., 1976; see also, e.g., Schultz and Adams, 1987; Steiner et al., 1994), these coauthors accurately recognize the lack of literature and policy statements available to guide hospital practices and the reluctance with which hospitals are willing to promulgate such policies (e.g., *Guidelines for Agency Policies,* 1993*;* Stefan, 1993; Quayle et al., 1998). This gap is complemented by a similar gap in the case law and in the legal literature. It is not surprising that staff mental health professionals at a facility in Canada have written, plaintively, "there is remarkably little literature and few sensible hospital policies to guide us" (Welch et al., 1991, p. 855).

This cannot be attributed to mere oversight or coincidence. It is probably not coincidental that one of the US Supreme Court's most chilling decisions of the twentieth century came in the infamous forced sterilization case of *Buck v. Bell*, in which Justice Holmes uttered his infamous dictum, "Three generations of imbeciles are enough" (1927, p. 207). The handful of recent cases that *has* been litigated on questions of the sexual rights of the institutionalized conveys a dominant set of messages: Judges—some of whom continue to endorse Holmes's dictum (see Robertson, 1991, as discussed in Perlin, 1992b, p. 373, n. 3)—are excruciatingly uncomfortable deciding these cases. By way of example, in *In re Guardianship of Mikulanec* (1984), the court upheld the constitutionality of a statute that had allowed for the appointment of a conservator for the limited purpose of approving or disapproving of the marriage of an institutionalized mental patient found to be "incapacitated" for the purposes of choosing a spouse, noting "because of a mental problem, she cannot realistically gauge men's affections for her" (id., p. 687). In this case, the patient had been found not guilty by reason of insanity in a "Fatal Attraction"–type murder of the wife of a man with whom she had been in love; the man whom she wished to marry was institutionalized as a sex offender who "prey[ed] on vulnerable women . . . with sincere words and superficial tenderness" (id., p. 685).

Also, lawyers are quick to abandon any allegiance to advocacy roles in litigating such cases. Lawyers are generally lackluster in representing individuals with mental disabilities and often fail to provide vigorous advocacy services, preferring a "best interests" model that capitulates to institutional power or preference (Perlin, 2008c*;* Perlin*,* 2003e; Perlin, 1992a). It is worth pointing out that individuals—including lawyers—who regularly take liberal and progressive positions on a full range of social and political issues often take contrary positions in matters involving persons with mental disabilities (Perlin, 1993; Perlin and Dorfman, 1993). Frequently, cases involving sexuality serve as a battlefield in which parents are pitted against their children over the question of the extent to which persons institutionalized because of mental disability can enforce this right (e.g., Stavis and Tarantino, 1986; Razack, 1995).

Significantly, the bulk of litigation in this area has come from applications of parents and guardians seeking to sterilize mentally disabled daughters whom they fear will become sexually active (e.g., *Matter of Guardianship of Eberhardy,* 1981 [parents feared their 22-year-old daughter had sexual contact with a male camper at a summer program for mentally retarded young adults]; *Interest of M.K.R.,* 1974 [parents sought sterilization of their "overly friendly" 13-year-old institutionalized daughter], and *Baise v. State*, 1998 [expert testimony sought to support the assertion that a girl was not capable of giving consent to sexual intercourse due to her mental retardation]). The most startling developments in this area of law and policy have come in the well-known case of Ashley X, a profoundly developmentally disabled child who received a high dosage of hormone treatments (and a mastectomy and hysterectomy) to stunt her growth and ensure that she would not develop sexually (for full discussions, see Koll, 2010; Carlson, 2012).

There are some isolated examples of sensitive judicial decisions. Professor Susan Stefan, by way of example, refers to *Foy* as "a model exposition of the reproductive rights of institutionalized women" (Stefan, 1989, pp. 432–33); in *State v. Green* (1990), the Tennessee Court of Criminal Appeals reversed a sexual assault charge that had been premised on the victim's being mentally incapacitated by nature of her institutionalization. In its decision, the court carefully weighed the factual record, and determined that, notwithstanding her disability, the "victim" retained the capacity to consent and that, in fact, the facility had allowed for the "victim" to have regular sexual encounters in her private room (id., p. *2). But notwithstanding cases such as these, this is an area in which nearly all of the participants in the judicial system join with the majority of hospital staff employees in wishing that the underlying problem would simply go away (Perlin, 1993–94).

Certainly, the most important recent case is that of *Kortner v. Martise* (2014). There, the plaintiff, the administrator of the estate of her daughter (the alleged victim and a person with mental disabilities), filed a complaint against a defendant for sexual battery, civil assault, and intentional infliction of emotional distress, stemming from a sadomasochistic sexual relationship that developed between victim and defendant and argued that her daughter had been legally unable to consent to sexual conduct. The Connecticut Supreme Court rejected this position, concluding that it was a fact question for the jury to decide "based on the nature of the particular conservatorships and the abilities of the conserved person," id., noting that conservatorship needed to be exercised via the "least intrusive means available by which the individual's affairs can be handled" (id., p. 445).

But cases of this sort are the exception and *not* the rule. It may be that the more typical judicial decisions in this area of the law are merely another manifestation of "sanist" behavior, i.e., that it is an irrational prejudice—based upon stereotype, myth, superstition, and deindividualization—that reflects and projects the community's conventional morality in a way that demonstrates bias against mentally disabled individuals just as racism, sexism, homophobia, and ethnic bigotry reflect other irrational prejudices (see Chapter 2). Perhaps it reflects the power of the ego defense of denial in matters involving psychiatric hospitalization (Dorfman, 1993), or it may be a residue of our historic conflation of "madness" and "sexuality" (Gilman, 1985). No matter what the interpretation, sexuality remains one of the most important and fundamental human rights for all individuals (e.g., Nicholson et al., 1996; Sy, 2001), and it is essential that we understand that reality as we consider the case law, legislation, and scholarship in this area of law and policy, never forgetting that both regulating sexuality and advocating for sexual rights can be viewed as proxy methods for advancing larger "conservative" and "liberal" agendas (see Neacsu, 2003).

II. Patients' Statutory Rights: The Americans with Disabilities Act

The Americans with Disabilities Act (ADA; see, generally, Perlin, 1997a) was initially hailed by advocates for persons with disabilities as "a breathtaking promise" (Milstein et al., 1991, p. 1240), "the most important civil rights act passed since 1964" (Ackourey, 1991, p. 1183, n. 1), and as the "Emancipation Proclamation for those with disabilities" (id., p. 1183, n. 2). It is, without question, "Congress' most innovative attempt to address the pervasive problem of discrimination against physically and mentally handicapped citizens" (Perlin and Cucolo, 2015, § 11-2), providing, in the words of a congressional committee, "a clear and comprehensive national mandate to end discrimination against individuals with disabilities" (*H.R. Rep.*, 1990, p. 23).

Although subsequent developments have led many—including one of the coauthors (MLP)—to "temper [their] enthusiasm about the ADA as a civil rights statute" (Perlin, 2001–02, p. 250; see also, Perlin, 2007, pp. 349–50: "early descriptions of the ADA as an 'Emancipation Proclamation' for persons with disabilities were probably overstated"), there is no question that, as the ADA does provide "basically the same bundle of protections for persons with disabilities as the Civil Rights Acts of the 1960s did for citizens of color" with clear, strong, and enforceable standards (Perlin, 1997a, 947–48), we continue to believe that it has "the *potential* to shift policies governing much of institutional and community-based mental disability law" (Perlin, 2008b, p. 510; emphasis added), including policies that consider the sexuality of persons with mental disabilities (compare Karlen and Rutherglen, 1996, reading the ADA as providing more protections than other civil rights acts).

It is important to note that certain sexual conditions—transvestism, transsexualism, and other "gender identity disorders"—were specifically *excluded* from the ADA (42 *U.S.C.* § 12211[B][1], 1990; see *Rentos v. Oce-Office Systems*, 1996, discussing exclusion of transsexualism). Interestingly, in the debate on the ADA on the Senate floor, Senator Jesse Helms asked pointedly, "How is an employer . . . supposed to find out whether a man is a *pedophile or a schizophrenic?*" (135 Cong. Rec. S10,766, 1989) (emphasis added). He also asked whether an "employer's own *moral* standards" might have enabled him to make hiring judgments about transvestites, kleptomaniacs, or manic depressives (135 Cong. Rec. S10,765, 1989, as discussed in Perlin, 2000c, p. 84) (emphasis added). But there was no discussion during the debate about the issues addressed in this book.

The language that Congress chose to use in its introductory fact-findings to the ADA is of extraordinary importance (on the "shocking and eye-opening" nature of these findings, see Lowndes, 1992, pp. 446–47). Its specific finding that individuals with disabilities are a "discrete and insular minority . . . subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness" (42 *U.S.C.* § 12101[a][7], 1990) is not just precatory "flag-and-apple-pie" rhetoric (see Tucker, 1992). This language—interpreted as granting "the force of law" (Miller, 1994, p. 413)—was carefully chosen; it comes from the heralded "footnote 4" of *United States v. Carolene Products* (1938, pp. 152–53, n. 4) that has served as the springboard for nearly a half century of challenges to state and municipal laws that have operated in discriminatory ways against other minorities (see, e.g., Rubenstein 1996, p. 339, concluding that the ADA's invocation of *Carolene Products* demonstrates justification for employing a "heightened judicial scrutiny" test; Rains, 1992; Lee, 1994).

It reflects a congressional commitment to provide "protected class" categorization for disabled persons (Coleman and Shellow, 1994, p. 151, n. 23;

Lowndes, 1992, p. 446). This language, in turn, forces courts to employ a "compelling state interest" or "strict scrutiny" test in considering statutory and regulatory challenges to allegedly discriminatory treatment (see, e.g., O'Toole, 1992). The law's invocation of the "sweep of congressional authority, including the power to enforce the fourteenth amendment" (42 *U.S.C.* § 12101[b][4], 1990) simply means that any violation of the ADA must be read in the same light as a violation of the Equal Protection Clause of the Constitution. This guarantees—for the first time—that this core constitutional protection is finally made available to persons with disabilities (see, e.g., Cook, 1991, p. 494, concluding that Congress considered disability classifications to be just as serious and just as impermissible as racial categorizations).[1]

What impact will the ADA have on the questions raised in this book? Can hospital procedures—either written or unwritten—that prohibit all patients from meaningful, voluntary sexual interaction survive ADA-based challenges? Congress's findings specifically acknowledged how "overprotective rules and policies" (42 *U.S.C.* § 12101[a][5],1994) discriminate invidiously against persons with mental disabilities. Certainly, many of the institutional rules banning sexual contact (see Chapters 2 and 4) flow from this discriminatory notion of overprotectionism.

The ADA's legislative history—as we seek to apply it to persons with mental disability—did focus specifically on questions of stereotyping and "reflects Congressional awareness of the pernicious danger of stereotyping behavior" (Perlin, 1997a, p. 968). First, the legislative history makes this clear through its heavy reliance on the Supreme Court's language in *School Board of Nassau County v. Arline* (1987), finding an individual with tuberculosis a "handicapped individual" under section 504 of the Rehabilitation Act of 1973, a predecessor law to the ADA, that "society's accumulated myths and fears about disability and diseases are as handicapping as are the physical limitations that follow from the actual impairment" (id., p. 284). Congress stressed that its inclusion in the definition of disability of an individual who is *regarded as* being impaired (42 *U.S.C.* § 12102[2][c], 1990) acknowledges this teaching about the power of myths (*H.R. Rep.*, 1990, pp. 252–54).

Second, the history of a qualifying section that requires that a putatively covered individual "not pose a direct threat to the health or safety of other individuals in the workplace" (42 *U.S.C.* § 12113[b], 1990)—also relying on the *Arline* case—specifies that, for persons with mental disabilities, "the employer must identify the specific behavior on the part of the individual that would pose the anticipated direct threat" and that the determination must be based on such behavior, "not merely on generalizations about the disability" (*H.R. Rep.* No. 101-485, pt. 2, 1990, p. 57). In such a case, there must be "objective evidence . . . that the person has a recent history of committing overt acts or making threats which caused . . . or which directly threatened harm" (id., pt. 3, p. 57).

As discussed earlier in this volume (see Chapter 2), our institutional sex policies flowed, in large part, from two contradictory stereotypes: one of infantilization (denying the reality that institutionalized persons with disabilities may retain the same sort of sexual urges, desires, and needs the rest of us have and generally upon which the rest of us act) and, paradoxically, one of demonization (expressing fear of their hypersexuality and the correlative need of protections and limitations to best stop them from acting on these primitive urges; see, e.g., Perlin, 1993–94, p. 537). How can these stereotypes be reconciled with this crystal-clear legislative history?

To what extent do the courts see sex as a fundamental right? Although the Supreme Court has never found sexual interaction per se to be a specifically protected right, and avoided the issue in both its 2003 decision finding unconstitutional a criminal sodomy state law (*Lawrence v. Texas)* and its 2013 decision finding that the Defense of Marriage Act violated the liberty clause of the Fifth Amendment (*United States v. Windsor)*, it has found a fundamental right to privacy in a broad array of cases involving reproductive choice (*Roe v. Wade,* 1973, p. 153), contraception (*Griswold v. Connecticut,* 1964, p. 485), interracial heterosexual marriage (*Loving v. Virginia,* 1967, p. 12), and family relationships (*Moore v. City of East Cleveland*, 1977, p. 503), and it has recognized a fundamental right to be free, "except in very limited circumstances, from unwanted governmental intrusions into one's privacy" (*Stanley v. Georgia,* 1969, p. 554). In 1996, the Supreme Court held that a state may not condition the right to appeal from a decision terminating a parent's rights on his or her ability to pay certain filing fees (*M.L.B. v. S.L.J.*, 1996). In the course of its opinion, the Court stressed that "choices about marriage, family life, and the upbringing of children are among associational rights [that it] has ranked as "of basic importance in our society" (p. 116), citing to, inter alia, *Skinner v. Oklahoma ex rel. Williamson*, a 1942 case finding a right to procreation. And, remarkably, on the day that the final manuscript of this book was submitted to the publisher, the Court ruled, in *Obergefell v. Hodges* (2015), that the fundamental right to same sex marriage was protected by both the Due Process clause and the Equal Protection clause of the Constitution, the Supreme Court noting that the right to "equal dignity" is so protected (id., p. 2608).

There is, in short, no compelling state interest to support a policy banning voluntary sexual interaction in hospital facilities. Any presumption of incompetence (see Chapter 2) that may be relied upon—either explicitly or implicitly—to support such a blanket proscription also fails to pass any sort of heightened scrutiny analysis, especially in light of the fundamentality of sexual experience as a constitutionally protected privacy right (Perlin, 1997a, pp. 969–70).

This is not to suggest, of course, that hospital facilities are not free to impose reasonable restrictions on inpatient sexual activity. One of the coauthors (MLP) acknowledged this in an article with two others (a forensic psychiatrist and a patients' rights advocate) nearly 20 years ago: "On a short-stay ward where acutely ill, voluntary and/or involuntary patients are hospitalized for at most a few weeks, it is reasonable to ask patients to refrain from sexual interaction" and to design ward policies with this expectation (Mossman et al., 1997, p. 453; for a recent study in Australia, concluding that different rules are appropriate in long- and short-term facilities, see Quinn and Happell, 2015b).

It is necessary to consider, in this context, the correlative right to be left alone. One federal circuit, by way of example, has found a fundamental constitutional right to be free from "forced exposure . . . to strangers of the opposite sex" when it is not necessary for a legitimate overriding reason (*Kent v. Johnson,* 1987, p. 1226). So, for a variety of clinical, administrative, and public safety reasons (see Perlin, 1993–94, pp. 540–45), carefully drawn limitations will pass ADA muster (see Mossman et al., 1997), as long as these policies are not based on stereotypes, allow for individualized decision making in individual cases, and authentically reflect a compelling state interest.

There has been virtually no ADA litigation on the issues discussed in this section. One of the few cases dealt with applicability of the ADA to questions of professional licensure where a physician whose license was revoked due to inappropriate sexual behavior with patients unsuccessfully claimed ADA violations because he was not referred to the Professional Rehabilitation Program on behalf of his claimed disability (*Shirazi v. Md. State Bd. of Physicians,* 2011). But none of the core issues referred to in this section have yet been the subject of litigation.

Perhaps the most interesting insights have come from the Supreme Court in the case of *Bragdon v. Abbott* (1998), holding that HIV infection was a disability within the terms of the ADA. There, the Court addressed the question of whether it considered that this impairment affected a "major life activity" (an ADA requirement, see 42 *U.S.C.* § 12201[a], 1990), focusing on the life activity of reproduction, and it had little problem determining that reproduction "*and the sexual dynamics surrounding it*" were "central to the life process itself" (id., p. 628; emphasis added). While subsequent courts "have not ventured into the query of which activities are part of . . . sexual dynamics" (Metnick, 2003, p. 95), it should be noted that more recent amendments to the ADA (the ADA Amendments Act of 2008) *have* listed reproductive functions as a "major life activity" within the law's meaning (*ADA Amendments Act of 2008*, Pub. L. No. 110-325, 2008), following a split in lower courts on the question of whether sexual relations *in se* are a "major life activity" (see Hryniewicz, 2010, pp. 428–30, discussing all cases; see, e.g., *Barron v. PGA Tour, Inc.,* 2009).[2]

Consider in this context the language of the Ninth Circuit:

> We conclude that engaging in sexual relations, just like procreation, is a major life activity. The number of people who engage in sexual relations is plainly larger than the number who chooses to have children. Moreover, according to the reasoning employed by the Fifth Circuit with respect to working as a major life activity, sexuality is important in how "we define ourselves and how we are perceived by others" and is a fundamental part of how we bond in intimate relationships. (*McAlindin v. County of San Diego*, 1999, p. 1234, relying upon *EEOC v. R.J. Gallagher Co.,* 1999, p. 654)

But none of this has had any impact, yet, on the questions we raise here. It is hoped that this state of affairs changes in the near future.

III. Patients' Rights: International Human Rights Law

A. The Convention on the Rights of Persons with Disabilities

As we have discussed in earlier sections of this book, and will discuss in later sections, simply put, people with disabilities are frequently stripped of their sexuality (Oliver, 1996; see, generally, Chapters 1 and 6). If we are to seek meaningful remediation of this situation, in addition to looking to constitutional and statutory law (see Chapters 3A and 3B), we must also carefully weigh the significance of international human rights law in this context (see, generally, Perlin and Lynch, 2015b).

Specifically, the ratification of the United Nations' Convention on the Rights of Persons with Disabilities (CRPD; 2007; see Perlin, 2011b) demands that we reconsider this issue. And we must begin our inquiry by noting that dignity—closely related to "inner worth" for these purposes (see Ploch, 2012, pp. 895–96)—is the first "fundamental axiom" upon which the Convention is premised (Lang, 2009, p. 273).

The CRPD "is regarded as having finally empowered the 'world's largest minority' to claim their rights, and to participate in international and national affairs on an equal basis with others who have achieved specific treaty recognition and protection" (Kayess and French, 2008, p. 4, n. 17). It is the most revolutionary international human rights document ever applied to persons with disabilities (Perlin and Szeli, 2012; on the potential application of forerunner UN documents, such as the International Covenant on Civil and Political Rights to these issues, see Perlin, 2008b). The CRPD furthers the human rights approach to disability and recognizes the right of people with disabilities to equality in almost every aspect of life (Dhir, 2005). It firmly endorses a social model of disability—a clear and direct repudiation of the medical model that traditionally was part-and-parcel of mental disability law (Perlin, 2011a). "The Convention responds to traditional models, situates disability within a social model framework, and sketches the full range of human rights that apply to all human beings, all with a particular application to the lives of persons with disabilities" (Lord and Stein, 2009, p. 256; see also, Lord et al., 2010; Kaiser, 2009). It provides a framework for ensuring that mental health laws "fully recognize the rights of those with mental illness" (McSherry, 2008, p. 8). There is no question that it has "ushered in a new era of disability rights policy" (Harpur, 2011, p. 1295).

In light of Convention Articles mandating, inter alia, "respect for inherent dignity" (CRPD, Art. 3), the elimination of discrimination in all matters related to interpersonal relationships (id., Art. 23), and services in the area of sexual and reproductive health (id., Art. 26), it is time for a radical change of perspective and attitude in how society views the sexuality, and right to express that sexuality, of persons with disabilities. A recent report on the treatment of institutionalized persons in Mexico is crystal clear: the lack of information available to patients about their sexual rights "is in direct contravention of . . . the CRPD" (Rodriguez, 2015, p. ii, referring to Article 31, mandating the collection of information that allows state parties to "formulate and implement policies to give effect to the Convention").

Article 23 is especially important in this context, because, in the words of Professor Carole Petersen discussing this precise topic, "contrary to stereotypes, persons with disabilities have active sexual lives" (2015, p. 154). Following the approach already adopted in international law, society as a whole must recognize that "being deemed a 'person' or sexual is not contingent upon ability" (Stevens, 2011, p. 16). Yet, the literature surrounding the sexual autonomy and issues of sexuality that people with disabilities continue to confront remains remarkably silent on this issue in general, falling prey to the ways that the taboos and stigma attached to sexual behavior are "inevitably heightened when . . . coupled with and conflated with stereotypes of the meaning of mental disability" (Perlin, 1997a, p. 965). It is equally silent about the issue we discuss in this subchapter: the CRPD's impact on the rights to sexual autonomy for persons institutionalized because of psychosocial or intellectual disability.

B. The Relationship between Mental Disability Law and Human Rights Law

In recent years, scholars have begun to focus more carefully and thoughtfully on the relationship between mental disability law and international human rights law (e.g., Dhir, 2005; Harpur, 2011; Lee, 2011; Hoffman and Könczei, 2010). In our own writings, we have explored this connection in the context of forensic facility conditions, correctional law, appointment of counsel, psychological evaluations in criminal cases, and how the law shames and humiliates persons with mental disabilities (Perlin and Lynch, 2014; Perlin, 2009a; Perlin and McClain, 2009; Birgden and Perlin, 2008; Perlin, 2008c; Perlin and Weinstein, 2014).

It is also significant to realize that the emergence of human rights—"their imagination and institutionalization—galvanizes the realm of national laws, for scholars and the wider society alike" (Frank and Phillips, 2013, p. 254). Long-standing prohibitions come alive under the new yardstick of universal freedom and justice as the national prohibitions confront the international protections (Boyle and Meyer, 1998; Halliday and Osinsky 2006, cited in id.). Certainly, the ratification of the CRPD will thus invigorate domestic laws as well. Interestingly, Japan deferred ratification of the CRPD until such time as its domestic laws were in accord with the body of international human rights law embodied in the CRPD (see Osamu, 2013).

We believe that the ratification of the CRPD demands that society and legislators alike reconsider this entire issue. First, the CRPD mandates nations to "provide persons with disabilities with the same range, quality and standard of free or affordable health care and programs as provided to other persons, including in the area of sexual and reproductive health and population-based public health programs" (CRPD, Art. 25). Beyond that, the other Convention Articles referred to above speak to dignity, the absence of discrimination, and the provision of sexual/reproductive health services. The Convention goes further than most legislation and court decisions, directly addressing not only the freedom to engage in sex, but *outcomes* of sexual activity, by codifying the right of the person with a disability to form a family, the right to information and services for sexual health, and, notably, the right to "retain their fertility on an equal basis with others" (id., Art. 23). A World Health Organization working paper underscores that "sexual and reproductive health personnel must work to overcome stigma and uphold the rights of persons with disabilities" (*Promoting Sexual and Reproductive Health*, 2009, p. 20). It also emphasizes, appropriately, in our view, that "the challenges to [sexual and reproductive health] faced by persons with disabilities are not necessarily part of having a disability, but instead often reflect lack of social attention, legal protection, understanding and support" (id., p. 6).

Yet, even given the specific and detailed language of the CRPD, the literature has been remarkably silent on these issues in general, especially as they relate to the CRPD's impact on the rights of persons institutionalized due to psychosocial or intellectual disability to sexual autonomy. Even the literature that speaks directly and eloquently to "sexual minority rights" under international human rights laws barely mentions those issues that specifically affect persons with mental disabilities (see, e.g., Persad, 2014). And, although the literature on physical disability and sexuality has grown significantly, "little global research on *developmental* disability and sexuality is visible" (International Council on Human Rights Policy, 2009, p. 62, n. 209).

There has been only sporadic attention paid to sexuality issues in the country reports issued by the UN Committee on the Rights of Persons with Disabilities, reports that are mandated by the CRPD (id., Art. 35). By way of examples, in Australia's report, the sole mention of sexuality issues notes that "the [Western Australia] Department of Health funds the Sexuality Education Counselling and Consulting Service, which develops and implements health promotion programs to enhance the health and wellbeing of persons with disabilities and educate the wider community in areas of sexuality and disability" (*Implementation of the Convention on the Rights of Persons with Disabilities* [Australia], 2012, p. 33, ¶ 152); in El Salvador, the sole mention states that, "in order to enhance the effectiveness of the Government's sexual and reproductive health programs, it is nonetheless important to provide for the various means of personal expression used by persons with disabilities, such as Braille or Salvadoran sign language, thereby ensuring that everyone has the information they need to make informed decisions" (*Implementation of the Convention on the Rights of Persons with Disabilities* [El Salvador], 2011, p. 35, ¶ 235); in Paraguay's report, there is no mention of sexuality at all (*Implementation of the Convention on the Rights of Persons with Disabilities* [Paraguay], 2011). This general lack of attention becomes even more significant when we consider how, in at least one CRPD signatory nation (China), the prevailing governmental policy is to prevent "pre-birth disabilities" via compelled abortion (Ng, 2012, pp. 1–2; on China's premarital medical screening examinations, see Hesketh, 2003; on the relationship between abortion and the CRPD in general, see Petersen, 2015).

Three scholarly articles in the literature stand out starkly as examples of what should be the focus of scholars' attentions: (1) Maya Sabatello's paper on the intersection between infertility, reproductive technologies, and disability rights law (2010), (2) Sabatello's paper on how sexuality was considered in the debate on the CRPD (2014), and (3) most directly, Marta Schaaf's article on sexuality in the context of the CRPD (2011). Drawing on Articles 2 (one of the "reasonable accommodation" articles), 23, and 26, Sabatello concludes that the CRPD provides a "possible venue to further advance a right to found a family through 'assisted reproductive technologies'" (2010, p. 259). In assessing the drafting process, she notes how all conversations about sexuality "raised acute debates" (2014, p. 257), and that, as a result, sexuality per se "was not elevated to a right" (id.; on the opposition of the Arab Group of nations, the Holy See, and Yemen to expanded mention of sexuality—unmoored from traditional marriage—see id.). Schaaf—who frontally notes that disabled sexuality is often perceived as a "threat to others" (2011, p. 114)—discussed the "tension" that underlay the negotiations leading to the adoption of the CRPD "between efforts to promote sexual rights and efforts to protect PWDs [persons with disabilities] from unwanted sterilization" (id., p. 124). Further, Schaaf notes that disability-focused NGOs "continue to be reluctant to engage sexuality" (id.) but concludes that "sexual rights as a rubric of rights' claiming will likely continue to grow, providing greater and better opportunities to move beyond current understandings of sexual citizenship to include disabled and all other bodies" (id., p. 125).

Professor Michael Stein and Professor Janet Lord have written eloquently about how *another* article in the convention—Article 30, setting out social rights of participation in cultural life—"serves as a vital channel of engagement with such society when such participation is accommodated in the community" and increases "self-reliance and empowerment" (2008, p. 182, as discussed in Perlin, 2008d, pp. 413–16). The CRPD Committee has begun to outline legislation and policies required to ensure implementation, a process that may prove useful in addressing many of the still-unanswered questions discussed here. The Committee has worked on issuing recommendations for services and programs aimed at people with disabilities to assist them in informed decision making regardless of whether they are institutionalized or not (*Guidelines on Treaty-Specific Document*, 2009). These programs would work on mainstreaming disability issues into legislation and disseminating information about sexual and reproductive health in an accessible format for individuals who want to become informed about their right to engage in sexual activity (Girlescu, 2012). Further, the Committee supports teaching sexual health to children with intellectual disabilities (*Guidelines on Treaty-Specific Document*, 2009).

We know from past history that, in the specific context of other United Nations Conventions, "[a] specialized human rights convention does not in itself guarantee substantial change" (Dillon, 2008, p. 154). If *this* Convention is taken seriously—if it is, in fact, more than a "paper victory" (Perlin, 2001–02, p. 246, quoting Lottman, 1976, p. 93)—then, perhaps, it can be a vehicle to uproot that aspect of sanism (see Chapter 2) that continues to deny institutionalized persons the rights to their own sexuality. There is some evidence that in other jurisdictions, parallel rights are being taken seriously. By way of example, in *X v. Iceland* (1976, p. 87), the European Commission on Human Rights has held that the prohibition in Article 8(1) of the European Convention on Human Rights barring public authorities from interfering with a person's right "to respect for his private and family life, his home and his correspondence" is broad enough to encompass an entitlement "to establish and to develop relationships with other human beings, especially in the emotional field for the development and fulfillment of one's own personality" (as discussed in Gostin and Gable, 2004, p. 94). Throughout the CRPD, it is apparent that the preferences and decisions of persons with disabilities must be respected and promoted. Expanding on this idea of self-determination, it follows that decisions about sex, sexuality, and reproduction are to be made by the person with a disability, rather than a "caretaker" or a facility superintendent, what is frequently termed "substituted decisionmaking" (see Perlin, 2013c; Salzman, 2011). This kind of decision making is a core element of self-determination and empowerment that is promoted by the CRPD (Girlescu, 2012). Girlescu elsewhere focuses on the case of *Shtukaturov v. Russia* (2008)—a Russian Constitutional Court case that concluded that the interests of a person under guardianship must be especially protected due to the significant loss of "fundamental rights and freedoms of people [in that status]" (Perlin, 2013c, p. 1170)—that recognized that "even persons under guardianship had the capacity to make their own medical decisions" (Girlescu, 2012, p. 34, quoting *Gauer v. France,* comments by advocacy coalition, 2011, p. 7). Relying on this decision, she concludes that, under international human rights law, "the issue of consent to sexual activities does not raise more problems than any other area in life in which the person is stripped of the ability of [making] decisions under over-inclusive guardianship systems" (Girlescu, 2012, p. 34).

However, in order to bring about such a dramatic shift in thinking (and translating that to concrete action that will allow for such decisions to be made by persons with disabilities) on this issue, it is necessary that other scholars follow the lead of Professors Sabatello and Schaaf to seriously engage this topic. As Professor Shirli Werner has plainly and simply put it, "Individuals with [intellectual disabilities] have the same needs for intimate relationships and sexual expressions as everyone else" (2012, p. 16; see also, Eklund and Ostman, 2009, discussing, in the same context, persons with persistent mental illness). The fact that the persons with mental disabilities are perceived—even by human rights policy groups—as persons with "limited agency" makes this an even more difficult problem (see International Council on Human Rights, 2009, p. 42: "How can sexual rights policies frame the state's obligation to facilitate and respect the rights of people, in all their diversity, including people who have limited agency [who are in prison, for example, or who have developmental or physical disabilities]?").

Yet, there is some cause for optimism. As will be discussed more extensively below, Willene Holness questions whether South Africa's sterilization law meets the requirements of the CRPD and concludes that the enhancement of the decision-making capacities of the population in question will require "demystifying the sexuality of women with disabilities" (2013, p. 35). Clearly, sexual health for persons with intellectual disabilities is a rights issue under the CRPD (Foley and Kelly, 2009). It is essential, however, that more scholars and advocates involve themselves in this enterprise and consider seriously the insights of Professors Mindy Jane Roseman and Alice M. Miller:

> Sexual rights at the global level are simultaneously utopian, pragmatic, and dangerous. They are utopian in that they partake of the human rights language of humanity, universality, conscience, freedom, equality, and dignity. They are pragmatic (and somewhat dangerous) in their incorporation through the international law regime, with its language of sovereignty, international agreement, rules of interpretation, entry and exit, state responsibility, and state consent. Moreover, as with any rights-developing process in international law, delineating the scope of state obligations toward sexual rights (i.e., what is the package of guarantees and promises for action which the state will undertake as part of accepting sexual rights as human rights?) becomes a key part of the process of norm-making. (2011, p. 318)

IV. Patients' Rights: Comparative Law

A. Introduction

Scholars are just beginning to consider the broad category of "sexual rights" in a comparative perspective (Frank and Phillips, 2013), a topic of scholarly consideration that "was blocked" for decades "and is only now emerging" (id., p. 250). In fact, the authors of the most comprehensive article available note that "matters once *unspeakable*, and even *inconceivable*, have [finally] entered the ivory tower" (id.; emphasis added). As social taboos began to lift in the late 1960s and early 1970s, "sex research stirred." But the early focus was "overwhelmingly" domestic (id.) and the early inquiries were strictly Western; "the rest of the world remained shrouded" (id.). In more recent years, however, comparative inquiries have broadened beyond the West, and we are now beginning to understand how the issues addressed in this book are considered in Asia and the Middle East as well.

At the outset, though, it is necessary to note that "there is no common or universal agreement about what the term 'sexual rights' might mean" (Richardson, 2000, p. 128). And, much of the new research has focused on areas of inquiry peripheral to the core of this book: same-sex unions and marriages (Kollman, 2007), asylum and refugee status (Fullerton, 1993), sexual violence (Stotzer and Lau, 2013), citizenship (Bell and Binnie, 2000), and parental rights (Polikoff, 2000), all leading to a "loose body of comparative studies of sex laws" (Frank and Phillips, 2013, p. 261). In their ground-breaking consideration of these issues, the sociologists David John Frank and Nolan Edward Phillips concluded:

> The current literature largely clusters on hot topics such as human trafficking or sex work, same sex unions or marriages, and sexual citizenship. The field would benefit from scholarly work pursuing the topics that receive less attention—because they are taken for granted (straight rights), because they are stigmatized (pedophile rights), or because they are not ontologically elaborated (intersex rights). (2013, p. 262)

The topic that we discuss here has never been seen as a "hot topic" like the ones that Frank and Phillips list. We hope that this volume inspires the same sort of interest that the listed areas have attracted in recent years. In the subsequent sections of this subchapter, we will consider the relevant issues in different regions and nations.

B. An Asian Perspective

1. On Cultural Relativism

We begin by addressing the issue of "cultural relativism" (see, generally, Perlin, 2011b; Perlin, 2012) that has infected all discussions about the applicability of human rights in Asia. Our position here is clear and unyielding: Cultural relativism should not and cannot be used as a defense in ignoring human rights, and is not sufficient justification for the denial of the universal application of human rights standards (see Hui, 2002; Paul, 2000; Davis, 1998; Tay, 1996; see Perlin, 2008b).

There is a difference between "adhering less to some global standard of human rights in order to promote overall human rights in socioeconomic realms and not adhering to certain rights because of a lack of political will or hiding behind the mask of cultural relativism" (Monshipouri, 2001, pp. 25–26). As Arati Rao has stated, "the notion of culture favored by international actors must be unmasked for what it is: a falsely rigid, ahistorical, selectively chosen set of self-justificatory texts and practices whose patent partiality raises the question of exactly whose interests are being served and who comes out on top" (1995, p. 174; see also, Preis, 1995, examining and rejecting cultural relativism from an anthropological perspective). In practice, cultural relativism rarely is a sincere call for tolerance (Sloane, 2001).

When cultural relativism is cloaked in the guise of "Asian values," proponents "argue that if 'Western' human rights treaties are respected in a given situation, the public will be worse off—thrown into civil war, vulnerable to insurgents, or, alternatively, unable to engage in the practices they value" (Posner, 2008, p. 1771). In other words, adhering to human rights obligations interferes with the government's welfare-promoting activities, and these welfare-promoting activities should take precedence (id.).

We disagree. We believe that the Asian values debate leads to false consciousness because it presumes a unified and homogenous multigenerational attitude toward a bundle of social, cultural, and political issues. The Asian values argument fails to account for "the richness of values discourse" in Asia (Davis, 1998). For this reason, some argue that there is no such thing as an Asian value (Engle, 2000). Further, assuming that there are uniform Asian values leads to generalizations and stereotypes of what is "Asian" (Tay, 1996). One such generalization is that Asian countries favor the community over the individual. Opponents of the Asian values debate question whether Asian governments are really interested in promoting development of communities over that of individuals. The broad state sovereignty claims of Asian governments are undermined given the "increasing reach of international law and the participation of all countries in the international legal order" (Peerenboom, 1999, p. 41). In addition, the Asian values debate assumes that culture is static, rather than varying from generation to generation (Tay, 1996). Rather, contemporaneous scholars conclude that "Asian perspectives on sexuality have been dynamic to begin with" (Lau, 2011, p. 778).

Advocates of cultural relativism "claim that rights and rules about morality . . . are encoded in and thus depend on cultural context" (Abtahi, 2007, p. 56, quoting Steiner and Alston, 1996, p. 192). We believe that cultural relativism is an inappropriate approach to this question, and unequivocally endorse the arguments of Patrick Hui, writing about birth-control policies in China in the context of the United Nation's Convention on the Elimination of All Forms of Discrimination against Women (CEDAW): "Cultural relativism is not sufficient justification for the denial of the universal application of human rights standards" (Hui, 2002, p. 199). Human rights as they apply to all aspects of mental disability law—including the right of sexuality—are universal.

2. Rights in China and Hong Kong

It is necessary to first look at China's history of mandatory sterilization of persons with intellectual disabilities (on sterilization generally, see Chapter 2). In the 1980s, laws were passed in Gansu province: first, forbidding individuals with "hereditary retardation" from having children (Johnson, 1997, pp. 221–22), then, mandating sterilization for such individuals (Gewirtz, 1994). Similar laws were enacted in other provinces, and within a few years, there were parallel laws in five other sectors, some forbidding marriage, some forbidding childbearing, and some mandating sterilization (id.; Martin, 2007). These laws, which apply to one-third of China's population, flowed in significant part from the predominant Chinese notion that mental disabilities were "inherited" diseases (see, e.g., Gewirtz, 1994, p. 149, mental retardation perceived to be inherited; Johnson, 1997, p. 226, n. 38, schizophrenia and manic depression presumed to be inheritable diseases).

China's 1994 Law on Maternal and Infant Health Care requires premarital checkups to determine the presence of "relevant mental diseases" (*Law of the People's Republic of China on Maternal and Infant Health Care*, 2007, Art. 7[3]), defined as mental diseases that "may have an adverse effect on marriage and child-bearing" (id., Art. 8[3]). The Chinese Marriage Law forbids marriage if either individual "is suffering from any disease that is regarded by medical science as rend[er]ing [sic] a person unfit for marriage," *Marriage Law of the People's Republic of China,* 1980, Art. 7(b), a category regularly construed to include mental disabilities (Feng, 2002). Beyond that, the law adds that an already-entered-into marriage is invalid "if any party has suffered from any disease that is held by medical science as rend[er]ing [sic] a person unfit for getting married and the disease has not been cured after marriage" (*Marriage Law of the People's Republic of China,* 1980, Art. 10[c]; on the medical examinations that must be taken prior to the issuance of marriage licenses in China, see Hesketh, 2003).

While China did enact a Law on the Protection of Persons with Disabilities (first in 1990, amended in 2008), Professor Carole Petersen glumly warns us not to assume that it brings China in compliance with the CRPD as it reflects an "overtly patronizing" medical approach to disability (2010, p. 93), noting that this law, ostensibly designed to prohibit discrimination against persons with disabilities, initially (preamendment) "endorsed policies designed to curtail their reproductive rights" (id., p. 102; on whether the amendments actually reflected a substantive change, see id.). In a thoughtful analysis of the paradox inherent in China's laws that both condone sterilization of persons with mental disabilities and reflect a "rhetoric of disability rights" (Ng, 2012, p. 24), Yee-Fui Ng has concluded, ruefully, "Disability policies in China have indeed come a long, long way, but there is still a long, long way to go" (id., p. 25).

Although Hong Kong now has comprehensive legislation prohibiting discrimination on the basis of disability (Petersen, 2013), standard governmental practices in other matters affecting persons with mental disabilities make us uneasy about being optimistic with regards to the question at hand. By way of example, in one case, three individuals had been denied jobs in a government department because each had a *mother or father* with a history of mental illness *K., Y., and W. v. Secretary for Justice,* 2000; see Petersen, 2001. Although the Equal Opportunities Commission successfully litigated under the Disability Discrimination Ordinance (DDO) on their behalf (see Petersen, 2002), the policy that had been previously enforced suggests that the sanism that we discussed earlier in this work still prevails at the governmental level (on Hong Kong's antidiscrimination laws in general, see Petersen, 1996). In a glimmer of optimism, Petersen calls our attention to using the fact that at least one judge has recognized that "gender dysphoria" falls within the definition in the Hong Kong DDO (Petersen, 2013, pp. 66–67). But elsewhere, she notes that members of the transgendered community frequently eschew the DDO and the CRPD as a potential source of rights, notwithstanding the fact that the CRPD seeks to "depathologize disability" (Petersen, 2011, p. 173; see also, Petersen, 2013, p. 79, on, in this context, "the movement to depathologize transgender identities"). By rejecting this strategy, they consciously distance themselves from a disability community, membership in which might be perceived as a sign of individual failure (on the courts' treatment of a DDO case involving a person with paraplegia who was mistreated by a taxi driver, granting the defendant's appeal from a lower court order that he apologize to the plaintiff, see Petersen, 2005, pp. 146–47).

3. Rights in Japan

Although the state of affairs in Japan is not quite as bleak, an article considering the role of the disability-rights advocacy movement in that nation notes that individuals with disabilities "have been taught from an early age to accept as well as cherish their dependence on the care they receive from parents and institutions" (Heyer, 1999, p. 17). In Japan, disabled women's freedom to express their sexual lives is severely limited (Osanai, 1989). Studies of the sexual lives of women with disabilities find that "negative attitudes contribute to the lack of control disabled Japanese women experience in relation to their own bodies and impede development of a sense of autonomy and freedom in relation to their sexual lives" (Yasuda and Hamilton, 2013, p. 51, and see id., discussing the "detailed numerous, sometimes very shocking, examples of the negative attitudes held towards the sexuality of disabled women in Japan by nondisabled Japanese women and men"). While scholars have begun to consider the negative social repercussions of principles of hierarchy and dependence in Japanese society (Bryant, 1991), they have paid little attention to the specific intersection between these principles and sexual autonomy.

4. Conclusion

These two portraits—a nation that seeks to suppress all sexuality in individuals with mental disabilities (see Hernandez, 2008), and a nation that privileges institutional dependence—do not lead to much optimism as we consider the matter currently before us. However, we do not want to paint an entirely pessimistic picture, as there is some recognition of the problem. In supporting the need for a UN CRPD, delegates to an Asia–Pacific regional conference held in Bangkok in 2003 declared that "international human rights standards require that people with disabilities should enjoy the same basic human rights as all other human beings" (*Bangkok Recommendations on the Elaboration of a Comprehensive and Integral International Convention,* 2003, as quoted in Perlin, 2008b, p. 501). Sadly, this statement appears at odds with prevailing social and cultural norms as well as legislation in much of this region (see, e.g., Chiu, 2007, discussing the possibility of creating an indigenous legal theory of sexual justice in Hong Kong). The delegates to the Bangkok Convention did note that such persons are subjected to "widespread violations of their human rights," including specifically, "forced sterilization" (*Bangkok Recommendations on the Elaboration of a Comprehensive and Integral International Convention,* 2003, as quoted in Perlin, 2008b, p. 501).

The CRPD and the Bangkok recommendations are encouraging. However, the backdrops of the Chinese and Japanese experiences remind us that realization of the rights set out in the Convention will not come easily. Advocates and activists in this area face barriers when seeking to articulate and implement an array of sexual autonomy rights for persons with mental disabilities. In short, this is not an easy question.

C. In the Mideast and Africa

1. Introduction

It is necessary to begin this inquiry with the realization that, in other areas of sexuality rights, it is not uncommon for the West to be "blamed" for the current state of affairs. Thus, foreign concern about Egypt's treatment of gay men bolstered the government's argument that homosexuality was a Western product (El Menyawi, 2012), and the argument that homosexuality is a Western threat to traditional societies was used by the Zimbabwe government to oppose the involvement of a Zimbabwean lesbian, gay, bisexual, and transgender (LGBT) organization in a human-rights themed book fair (Stychin, 2004). In at least one instance, this was seen as progressing from Westernized feminism: "Following in the footsteps of the white Western women's movement, which . . . sought to universalize its issues through imposing its own colonial feminism on . . . women's movements in the non-Western world—a situation that led to major schisms from the outset—the gay movement has adopted a similar missionary role" (Massad, 2002, p. 361).

With this backdrop, it is not a surprise that there have been few positive developments—with the exception of some voices in Israel (see below)—in these regions of the world in the area of sexuality and *disability.* It must be kept in mind that, among many in these regions, traditionally, the cause of mental illness has been crimes committed by one's ancestors (see Patel 1995), a category including sexual misconduct (see Edgerton, 1966).[3] "Excessive" sexuality was historically regarded as a cause of illness and insanity (Gregor, 1987, p. 6).

2. In Israel

Some twenty years ago, a government-sponsored report in demanded the establishment of single-sex psychiatric wards owing to the possibility of sexual activity among patients, who resided on mixed-sex wards. While producing an irate response from Israel's psychiatrists, it reflected the concerns of the country's ultraorthodox Jewish minority. There has been little literature on sexual behavior in Israel's psychiatric hospitals, consistent with the sparse international literature explained by Chase (1988) as reflecting an attitude of "out of sight, out of mind" toward hospitalized psychiatric patients. These recommendations were partially followed, but not without controversy. While the Israeli Health ministry more recently claimed that the reason for separation is professional, in order to improve patient care, a mental health specialist responded, taking the position that "these days, most experts believe that there shouldn't be separation, as patients staying in these facilities should be able to experience day to day life in which men and women interact, as much as possible" (Peled, 2010; see generally, Payne, 1993).

When a researcher interviewed the directors of three of Israel's psychiatric hospitals, they concurred that the attitude of staff is not to permit sexual intercourse on acute wards, as acute patients are not in a state to make a reasoned decision and are likely to have remorse for their actions afterward (compare, Mossman et al., 1997). Staff are alert to the possibility of advances being made to more vulnerable patients. Specifically, no facilities were provided for patients to have intercourse (Payne et al., 1993, p. 116).

Of course, one of the issues that are faced in nations such as Israel is the political strength of the observant religious community. According to religious law, masturbation is forbidden, and sexual relations are reserved for marriage. Within the community is a minority of ultraorthodox Jews, whose life is guided solely by religious law and who avoid contact with the secular population (Friedman, 1991). In this community, there is no social mingling of the sexes throughout life. With the exception of man and wife, and parents and children, ultraorthodox men and women neither touch each other nor remain alone in a room together. Thus, it should be clear why standard mixed psychiatric wards of Israel are anathema to this community (see also, Greenberg et al., 2010).

A controversial 1991 report by the Ministry of Health stated unequivocally that patients are incapable of giving consent to sexual intercourse (a conclusion contrary to all valid and reliable research and to international human rights law), so that intercourse with such a patient is an act of molestation, and argued that as the provision of a single-sex ward was a form of protection against molestation, hospitalization of a psychiatric patient in a *mixed-sex ward* exposed the ward director to the risk of criminal charges if intercourse occurred (Ministry of Health, 1991; Shereshewsky, 1991).

Israeli psychiatrists responded quickly, arguing that this report denied patients their rights to a personal sex life, and that, according to its conclusions, husbands having intercourse with their mentally ill wives were guilty of molestation (Ginat, 1991). They viewed the report as an attempt to intimidate hospitals into changing to single-sex wards via threats of criminal prosecution, using medico-legal means to achieve "religio-political ends" (Israel Psychiatric Association, 1992). More recently, there have been important "pro-sexuality" developments in Israel, and sexual surrogacy is now a legal and accepted practice (Rosenbaum et al., 2014; see Chapter 4, for a more extended discussion of surrogacy issues).

3. In Egypt

There is little but a survey done some two decades ago that might offer some helpful insights. Staff at Behman Hospital (a general psychiatric hospital of 250 beds south of Cairo) were asked a series of questions about patient sexuality. First, contraception would not be discussed with patients by medical staff, but by family members. Second, "no hospital would consider having a private area for sexual activity of patients"; in fact, it would not be uncommon for the family of a patient admitted to hospital to request a gynecological examination "confirming the patient's virginity." Finally, whether a patient was a voluntary or involuntary patient would have little or no impact on how issues as to sexuality might be resolved (Payne, 1993, pp. 118–21).

D. In Other Nations (on the Question of Patients' Sexuality Rights in Forensic Facilities)

1. Ireland

A major study commissioned by Ireland's Health and Safety Executive (HSE) makes clear that "sexual health for persons with an intellectual disability is a rights issue" (Foley and Kelly, 2009, p. 20), while acknowledging that that nation's 1993 Criminal Act makes it a criminal offense to have or attempt to have sexual intercourse with a "mentally impaired person" (id.). It notes further that there is "little policy within the area of sexuality and health promotion for persons with an intellectual disability and there are major legal barriers to the development of policy within an Irish context," adding that among the implications of this lack of policy is the fact that "many persons with an intellectual disability are being denied a basic human right to form relationships," and that, as a result, contemporary policy is moving toward an emphasis on rights and the promotion of sexual health (id., p. 13). The study concludes by calling for the "development of a political will" so as to "ensure the provision of relationships and sexuality education within care settings" (id., p. 26).

A more recent study done by Ireland's National Disability Authority endorses the findings of McCarthy and Thompson (2004), stating that in the learning disability field, people must have free choice and informed consent when it comes to sexual relationships. Conditions that should exist for free choice include the following:

- For valid consent to sex, women with learning disabilities must know that sex, especially when initiated by a more powerful person, is not required and compulsory.
- People must have sufficient communication skills to be able to make their choice (to engage in sexual activity or not) known to the other party. This means that either verbally or through an alternative communication system known to both parties they must be able to give/deny/withdraw consent at any stage in the activity. Silence or non-communication must not be interpreted as consent.
- There needs to be a reasonable degree of equality between the parties, so that both parties have sufficient power to make the choice to engage or not engage in sex, without fear of adverse consequences (National Disability Authority, 2014).

2. United Kingdom

Twenty years ago, researchers noted that "sexuality is a difficult subject for both patients and staff to discuss. Victorian attitudes of prudishness and a reluctance to accept and talk openly about sexual behaviour are still prevalent in British society" (Payne, 1993, p. 127). To what extent has this changed in the intervening years?

While attitudes about sexuality may remain somewhat repressed, some changes have brought about a set of standards for individuals in psychiatric facilities. In 1996, the Royal College of Psychiatrists recommended that all psychiatric facilities in the UK develop policies concerning sexuality and sexual expression for persons contained in those facilities. While this sounds like a potentially positive step, and while the College did in fact recommend an individualized approach to sexual and emotional relationships, most hospitals in fact either prohibit or actively discourage such expression as a matter of policy (Bartlett et al., 2010). A study of comparative policies in England and Wales found a great number of inconsistencies; for example, in one high-security facility, patients were able to request and receive condoms with the consent of a treating clinician, while in another facility, condoms were expressly viewed as contraband (id.). Other facilities allowed conjugal visits, while some only allowed visits in public areas where no intimate contact was allowed. The rules of Broadmoor (forensic) Hospital are clear—"sexual relationships between patients are prohibited," but they quickly note, "it is accepted that such relationships cannot be totally prevented and procedures are therefore needed to ensure as far as possible that any such relationships are appropriately managed" (West London Mental Trust, 2015, § 2.4).

However, even when a facility had a slightly more relaxed view of sexual autonomy, and did not expressly prohibit condoms, physical contact, or peer relationships, Bartlett and his colleagues found that policies dictating sexual autonomy and expression still left "extraordinary" amounts of discretion to the treatment team, in determining whether a relationship was appropriate or not (Bartlett et al., p. 160). In this area of law, there remains a great deal of tension, and one's ability to express sexuality and to engage in relationships may entirely depend on the facility in which he or she is currently confined.

The statutory law in the UK (England and Wales) is now relatively clear, at least when it comes to the question of when a person with a mental disability is potentially victimized, creating three sets of offenses: Offenses concerned with sexual activity involving a person with a mental disorder—these apply where the person cannot consent to the sexual activity (*Sexual Offenses Act of 2003*, §§ 30–33); offenses where the person's agreement to engage in sexual activity is secured through an inducement, threat, or deception (id., §§ 34–37); and offenses where the defendant is in some form of care relationship with the complainant; these offenses may be committed regardless of consent (id., §§ 38–41). Commentators have suggested that this law is an example of a positive development toward "striking a balance between sexual rights for people with learning disabilities and protection from exploitation" (McCarthy and Thompson, 2004, p. 238).

3. Australia

In most states in Australia, the knowledge required for legal consent to a sexual act is only that the person understands the nature of the act (Graydon et al., 2006) but there is no need to know the consequences (see, generally, National Disability Authority, 2014). The standard in Victoria is less stringent; there, it must simply be proven that the person does not have sufficient knowledge or understanding to comprehend either that sex may involve physical penetration of the body or that penetration is an act of sexual connection, as distinct from an act of a totally different character (*In re Morgan*, 1970). According to the Victorian Law Reform Commission (2001), using this standard most people with impaired mental functioning will be capable of consenting to sexual activity. On the other hand, most Australian mental health facilities have adopted guidelines that prohibit sexual activity between patients in acute units, and clinicians are encouraged to actively prevent and discourage sexual intimacy between patients (Quinn and Happell, 2015b).

At least one Australian facility, the Thomas Embling Hospital (a high-security forensic facility), has promulgated a complex series of sexual behavior policies, including practice guidelines, recommendations on sexual health, and advice on how staff can be sensitive to family needs (on the influence of family factors on the course of psychiatric illness, see Vaughn and Leff, 1976). Noting that the underlying issues are "more complex" in a secure forensic mental health service (*Sexual Health Practice Guidelines—Thomas Embling Hospital*, 2014), the policies conclude that while "consensual sexual activity occurring between patients within Thomas Embling Hospital is not encouraged," what sexual activity that occurs must not be "offensive or disruptive to the therapeutic milieu," and that "a harm minimization approach to the management of sexual activity is to be implemented" (*Sexual Health Policy*, 2014). The policies note further that the managing mental health service (Forensicare) "will seek to provide a framework for staff to be responsive and consistent in their approach to the intimacy and sexuality needs of patients," noting that "sexual behaviour is a complex issue for clinical staff to manage in an accountable, consistent, professional and humane manner" (*Sexual Health—Thomas Embling Hospital*, 2014).

E. Conclusion

Ultimately, a comparative law analysis shows us that we remain in a period of great tension, not just between different nations (see Tiwana et al., 2015), but even within the bounds of the same nation. While some facilities may be starting to recognize that individuals with disabilities have desire and ability to engage in sexual relationships, the stagnant, repressive attitudes toward sexuality and sexual expression continue to undermine any great shifts in policy. This status quo can come from history, religion, or general conservative ideologies of a population; however, it will continue to force individuals with disabilities all over the world to face the fact that their natural expressions of sexuality are deemed unwelcome or unnatural enough to require strict scrutiny of their sexual behaviors and the promulgation of policies that limit or ban sexual expression.

V. Inquiries into Competence

A. Introduction

We need to begin this inquiry with the observation that dignity concerns and rights violations will occur if there is not a full understanding of the importance of the ability for persons with mental illness to practice free sexual expression. There has been some literature that begins to discuss this and to delve into the intricacies of the subject (compare, e.g., Smith, 2006, p. 20, in the context of correctional institutions: "Permitting a greater degree of sexual expression recognizes the inherent dignity and autonomy of human beings"). However, much of the discourse about persons with mental disabilities presumes that this population—especially those who are institutionalized—are incompetent. In this book, we reject the notion that incompetency can be presumed and deal, instead, directly with the very likely situation of a mentally ill person—presumed by law to be competent (see, e.g., Perlin and Dorfman, 1996, p. 120: "Contemporaneous constitutional case law and some statutory law generally reject the idea that mental illness and incompetency can be equated")—who wishes to engage in sexual activity. We will examine legal competency, as well as the difficulties encountered when one begins to use different measures of "competency" for different tasks or activities. We will also explore the attitudes that surround this type of discourse, and their impact on advancing the rights of persons with mental illness (see, generally, Perlin and Lynch, 2014).

As part of this inquiry, we will first seek to determine if there is any unitary definition of competence, then seek to enumerate the factors (if they, in fact, exist) that must be considered in determining "sexual competence" and weigh this in light of the domestic law and policy discussed in the previous sections of this chapter (on the knotty issue of defining what "sex" is for these purposes, see Chapters 1 and 6). We will then consider an array of competence-specific questions that must be addressed if a full picture is to emerge:

- Do rules of evidence that relate to the capacity of a person with a mental disability to testify when she or he has been the victim in a sexual abuse case need to be modified?
- Must statutes and case law that consider the rights of persons with mental disabilities to marry be restructured?
- Must "statutory rape" laws (that presume incompetence and equate persons with mental disabilities with children) and sterilization laws be radically reconceptualized (or, perhaps, repealed)?
- Are there vestiges left of our tragic history of sterilization policies, and to what extent are competence inquiries actually taken into account?
- Have the issues that surround both dementia and institutionalization in nursing homes and other geriatric facilities been seriously considered in this context?
- Is there a difference in cases of persons with psychosocial disabilities and intellectual disabilities?
- Can persons with mental disabilities take the same sort of *risks* in sexual activity that others regularly do? and
- Is institutionalization *in se* improperly factored in to competence decision making, both in the cases of individuals in civil hospitals and in forensic facilities?[4]

We will first discuss the global factors that must be considered before we proceed to the heart of the inquiry, and we will then address each of the issues listed above.

B. Factors to Consider in Assessing Competence to Have Sex

We must start with the assumption that all individuals have the capacity to consent to sexual relations, and that the presence of a mental disorder, in itself, does not mean that the individual lacks this capacity (Mental Welfare Commission for Scotland, 2012). It is essential that sexual incapacity doctrines be reconfigured "so that they are not a disabling force for people with persistent cognitive impairments" (Boni-Saenz, 2015, manuscript, p. 55). With this as a "given," it is first necessary to unpack the different modes of analysis to be engaged in determining capacity and competency, and understanding the important distinctions between the two concepts. Capacity "refers to an individual's actual ability to understand, appreciate, and form a relatively rational intention with regard to some act" (Bisbing, 2007, p. 325); however, inquiries into capacity are an insufficient basis for decision making about persons with mental disabilities engaging in sexual interactions (Dimopoulos, 2012). It is clear that a functional, rather than diagnostic, approach to determining capacity is now the preferable means of assessment (Murphy and O'Callaghan, 2004).

Competency is a *legal* assessment that varies based on the act or decision making that is being considered (Perlin et al., 2008). Most famously, dissenting in *Godinez v. Moran* (1993), in which the Supreme Court imposed a unitary standard of competency in criminal cases, holding that competency to waive counsel or to plead guilty was to be assessed by the same standard as competency to stand trial, Justice Harry Blackmun noted archly, "A person who is 'competent' to play basketball is not thereby 'competent' to play the violin. Competency for one purpose does not necessarily translate to competency for another purpose" (*Godinez,* 1993, p. 413; on the need to consider competencies in matters of sexuality as a distinct area of inquiry, see Girlescu, 2012). Importantly, the Supreme Court subsequently receded from the rigidity of the *Godinez* holding in *Indiana v. Edwards*, 2008, ruling that the right of self-representation was not absolute and the State could insist that an attorney be appointed to represent a mentally ill defendant even though he had been found competent to stand trial (Perlin and Cucolo, 2015, § 13-2.8.5). In the course of the *Edwards* decision, it characterized the issue in a multitextured way that should be taken seriously in any consideration of the issues we are discussing in this chapter:

> Mental illness itself is not a unitary concept. It varies in degree. It can vary over time. It interferes with an individual's functioning at different times in different ways. (*Edwards,* 2008, pp. 175–76)

This approach must be intertwined in assessing the extent to which a person can exercise informed consent. In the context of this inquiry, such consent encompasses:

- An individual's ability to understand the sexual nature of an act, and to understand that participation in such an act must be voluntary;
- An individual's understanding of the potential consequences and implications of the decision to engage in a sexual act; and
- An individual's ability to communicate a decision in an overt manner as to whether he or she wishes to engage in such an activity (Doyle, 2010; see also, Lyden, 2007; Abramson et al., 2012).

There is also the difficulty of establishing "clinical" competency, for those persons who are institutionalized. There is no standard that clinicians regularly apply when determining competency; in fact, it is an extraordinarily fluid determination (see *Niswonger v. State*, 2013, p. *1, n. 2). In a survey of institutions' views on their ability to handle ethical concerns of patient sexual expression, the sociologist Eric Wright and his colleagues found, "aside from formal legal declarations of incompetence, establishing competence to engage in sexual activity during treatment is further complicated by the dynamic nature of psychiatric symptoms, variation in patients' sexuality-related knowledge and experience, and institutional policies" (2012, p. 2). In this context, it is also important to consider the reality that, *in general,* "Americans and their legal systems became increasingly liberal regarding adult sexuality and the privacy afforded private, consensual, adult sexual relationships in the twentieth century" (Elimelekh, 2006, p. 286). But, in the context of the current inquiry, the relationship between sexuality and privacy is "directly related to assessments about . . . competence" (Gill, 2012, p. 476).

This is not to say that there are not models that could be followed. By way of example, Murphy and O'Callaghan have created a multistep instrument that could be adopted by inpatient psychiatric institutions as a guide. They conclude that these are all important areas to be considered in assessing capacity:

1. Basic sexual knowledge (e.g., of body parts, sexual relations, and sexual acts);
2. Knowledge of the consequences of sexual relations, including sexually transmitted diseases and pregnancy;
3. An understanding of appropriate sexual behavior and the context for this;
4. An understanding that sexual contact should always be a matter of choice;
5. The ability to recognize potentially abusive situations; and
6. The ability to show skills of assertion in social and personal situations and to thereby reject any unwanted advances at a given time (2004, p. 1347).

The authors also stress that, in such inquiries, physicians should always be in full consultation with those who are involved with the person in a professional or a caring role (id.).

We need to stress that, historically, there are other cohorts about which incompetency has been presumed, ranging from children (Rodham, 1973) to pregnant schoolteachers (Lucas, 2013), and that lawyers have traditionally presumed incompetency *in all matters* that relate to their institutionalized clients (Perlin, 2008c), the latter notwithstanding the fact that, in many jurisdictions, it is statutorily impermissible to do precisely that (see, e.g., *N.J. Stat. Ann.* § 30:4–24.2(c), 2014). But it is done unthinkingly, and virtually universally, in the context of the population considered here, and it is clear what a "damaging message" (Best, 2012, p. 488) this is. This, more than anything else, leads to the confusion, dissonance, and tension in this area of law, society, and personhood.

In subsequent chapters, we will discuss, as noted before, the conversation as to what "sex" means, and, in this context, explore the ways society constructs differently "vanilla sex," homosexual sex, other sexual activities with a partner (or partners), and masturbation (see Chapter 6). But we believe that, in general, the many variations of sexual activity between consenting adults must be considered in the same way that "basic" heterosexual sex is considered. Competence to engage in sexual activity should never be prefaced on the *type* of activity an individual wishes to engage in, no matter how taboo or "transgressive" (Donnan and Macgowan, 2009). An ongoing difficulty in this area is ensuring that all these forms of expression, plus others not covered here, have the same standards of competence applied to them.

Elaine Craig writes, "Unavoidably, a law that denies capacity to consent to a particular sexual act also affects individual liberty. A legal rule that denies capacity to consent to a particular sexual act circumscribes sexual liberty by depriving individuals of the ability to legally engage in sex that they might desire" (2014, p. 105). Craig highlights a key point: Sexual activities that fall outside the "mainstream" deserve equal treatment in facilities, and the desire to engage in such acts must be recognized by these facilities as being an equally valid sexual desire.

We must be aware that in institutions, individual providers' religious, ethical, or moral beliefs often come into play; "Even if policies are promulgated that protect and respect the sexual autonomy of institutionalized individuals, what happens when individual line staff at a hospital, the people to whom the implementation of the policy inevitably falls, simply refuse to cooperate with the policy because their own sense of religious 'morality' forbids it?" (Perlin, 1993–94, p. 526; see also, Bahner, 2012, p. 338: "Personal [care] assistants' beliefs and moral judgments have been shown to strongly influence, and cause attitudinal barriers in, sexual expression"). This can be especially toxic because staff (especially nursing staff) disapproval results in the further stigmatization of the behaviors in question (Quinn and Happell, 2015a; Berer, 2004), thus increasing the impact of sanism (see Chapter 2). In short, staff should "not allow their personal prejudices, judgements or sexual preferences to affect their work" (Mental Welfare Commission for Scotland, 2012, p. 17).

Over 20 years ago, Clarence Sundram and Paul Stavis enumerated multiple factors that *courts* have considered in individual cases in assessments' of institutionalized intellectually disabled persons' competency to engage in sexual activity:

- The differentiation between chronological age and what is termed "mental age," i.e., the recognized behavioral level quantified in terms of a developmental age usually substantially below the legal age of adulthood;
- The intelligence quotient (IQ) score and the general level of intellectual disability and functional abilities, such as the ability to read and write, to count, to operate household machinery, to perform household chores to run errands, to hold a job (differentiating sheltered workshops from other employment), to travel alone or remain without supervision, and to count or manage money;
- Attendance at a school or special program for persons with retardation or residence in an institution for persons with intellectual disability; and
- Actual knowledge of the sex act, diseases, pregnancy, etc., and an ability to resist coercion of authority figures (1993, p. 452).

Yet, the reality remains that most decision making as to questions of "sex on the wards" (Mossman et al., 1997) is done by line staff with virtually no accountability.

Regardless of how they choose to express themselves sexually or with what subculture they identify, patients must be evaluated individually. Unique characteristics and sexual preferences of an individual will not make that individual "less competent" to engage in his or her preferred type of sexual activity, even if it means that such individuals are not consenting in a traditional way but still desire and understand the sexual activity.[5] Also, individualized treatment is critical because, in considering the elements of a patient's hoped-for recovery, the evidence is clear that, postrelease, patients will have the opportunity to make decisions and choices about sexual relationships; by closing our eyes to this reality, we make it less likely that such recovery will be a reality (Quinn and Happell, 2015a; Tennille and Wright, 2013).

Just as a person with a mental disability is entitled to individualized treatment, his or her sexual ability and interests should be viewed as a unique characteristic that merits an individual plan and attention. Implementing a universal plan for patients in a facility or those in the community that outlines a standard measure of acceptable activities and consent will not allow an individual with mental illness to gain pleasure from desired sexual activities, which, with few exceptions, other members of society at large are able to do (on the controversy as to whether sexual intercourse is a medical necessity or merely a question of "quality of life," see Beh, 1998). While the sexual components of competency are a critical consideration, especially for those individuals confined in a psychiatric facility, there are a multitude of other issues that involve a presumption of competency (or, alternatively, the presumption of incompetency). When this latter presumption exists, there is always the possibility for disparate treatment of people—virtually always improperly—deemed incompetent.

C. Specific Competence Questions

1. Persons with Mental Disabilities as Witnesses

It is black-letter law that competency to testify is presumed unless the witness is of "unsound mind" (see, e.g., *Ohio Evidence Rule* 601, 2014, for a typical example of such a law; The test as to whether or not one is of unsound mind has been stated this way by an Arizona court:

> The test to determine whether a witness' mind is so unsound as to require that he be excluded as incompetent to testify is whether the witness' mental derangement or defect is such that he is deprived of the ability to perceive the event about which he is to testify or is deprived of the ability to recollect and communicate with reference thereto . . . in general, when a proposed witness' competency is called into question, discretion should be exercised in favor of allowing the witness to testify. (*Zimmer v. Peters*, 1993, pp. 1190–91)

Courts, however, have expressed great concern about allowing persons who are or who have been institutionalized to testify. The lead case of *Sinclair v. Wainwright* sets out the prevailing position:

> Turning then to the merits of appellant's due process claim, it may be noted "that a [person with mental disability] may be allowed to testify if he is able to [comprehend] the obligation of an oath and give a correct account of matters he has seen or heard" [*Shuler v. Wainwright*, 491 F.2d 1213, 5th Cir., 1974]. But if a patient in a mental institution is offered as a witness, an opposing party may challenge competency, whereupon it becomes the duty of the court to make such an examination as will satisfy the court of the competency of the proposed witness [id., pp. 1223–24]. And if the challenged testimony is crucial, critical or highly significant, failure to conduct an appropriate competency hearing implicates due process concerns of fundamental fairness [citation omitted].
>
> This is not to say "that every allusion as to incompetency of a witness [is to] be exhaustively explored by the trial judge, particularly where all other evidence substantiates competency" [*United States v. Crosby*, 462 F.2d 1201, 1203 n. 5, DC Cir., 1972]. But in the present situation, as in *Crosby*, we

> believe a “red flag” of material impact on competency was flying. [The potential witness] was offered as an eyewitness to many of the critical aspects of the state’s case against Sinclair. He had been declared incompetent to stand trial by the judge who was trying Sinclair. Only by a reasonable exploration of all the facts and circumstances could the trial judge exercise sound discretion concerning the competency of the witness and the findings of the court with respect to competency should have been made to appear on the record. The record reflects no searching exploration and no stated reasons for overruling appellant’s competency objections. In such circumstances, we are obliged to remand for a determination on the record of the competency of the witness. (*Sinclair,* 1987, pp. 1522–23)

At least one of *Sinclair’s* assertions—its reliance on *Shuler* for the proposition that “if a patient in a mental institution is offered as a witness, an opposing party may challenge competency, whereupon it becomes the duty of the court to make such an examination as will satisfy the court of the competency of the proposed witness” (*Sinclair,* 1987, p. 1522, quoting *Shuler*, 1974, pp. 1223–24)—is seriously flawed. As a matter of law, incompetency cannot be presumed as a result of either mental illness or institutionalization (*In re Labelle,* 1986, p. 146). Furthermore, there is “no necessary relationship between mental illness and incompetency which renders [mentally ill persons] unable to provide informed consent to medical treatment” (*Davis v. Hubbard,* 1980, p. 935). Yet, it is clear that courts will continue to, *sub silentio*, follow this doctrine, especially in criminal cases (see Perlin, 2003a, pp. 303–5). A Canadian study found “repeated examples of complainants whose evidence is given diminished weight because of their mental disability” (Benedet and Grant, 2007, p. 525).

The issue here becomes much more problematic and complicated in cases in which a person with a mental disability is alleged to be a victim in a case of sexual assault, a cohort of cases that is especially important because, in many instances, “it is not only their bodies and minds that are being abused, but also their vulnerability, and oftentimes, their trust” (Beaudry, 2014, p. 10). Traditionally, persons with intellectual disabilities have been excluded from the legal system based on the belief that they are incompetent to provide accurate, reliable testimony (Valenti-Hein and Schwartz, 1993). This exclusion is based primarily on stereotypes about this cohort of persons, stereotypes that reflect the rankest sanism in the legal system (see Chapter 2). As Professors Valenti-Hein and Schwartz have noted, “Generalizations about people with mental retardation are particularly problematic because mental retardation, like competency, is a multi-dimensional concept” (id., p. 290), representing, for example, “people with a wide range of IQ scores (from 0 to 80) and abilities (from those who cannot feed, dress, toilet, or speak for themselves to those who reside virtually undetected in the community)" (Denno, 1997, p. 329, n. 82).

This reluctance to allow persons with intellectual disabilities to testify is especially damaging given the reality that this population is estimated to be sexually victimized at four to ten times the rate of those without such disabilities and that this disparity is greatest for those who are institutionalized (Denno, 1997; Sobsey and Doe, 1991; Sundram and Stavis, 199; Valenti-Hein and Schwartz, 1993; Stuart and Stuart, 1981). And, in the cases of those who are institutionalized, much of this sexual abuse or assault is directly attributable to the victim's institutional or residential home placement, as over one-third of the assaults are committed by the service providers themselves or their employees (Denno, 1997; Berkman, 1984, p. 89).

It is also important to understand that competency in one area is not a valid criterion in determining an individual's competency to consent to sexual relations. In other words, individuals' competency as to, for instance, financial decision making is not dispositive of their competency to consent to sex, an issue that arises frequently in cases alleging that persons with disabilities had been sexually victimized (*State v. Soura*, 1990; *State v. Peters,* 1983; *State v. Ortega-Martinez*, 1994; Reed, 1997; Valenti-Hein and Schwartz, 1993).

In addition, we cannot lose sight of the realities that (1) the problems are magnified by the "tendency to infantilize women with mental disabilities, thereby diminishing their credibility and depicting them as hypersexual when they engage in any sexual activity" (Benedet and Grant, 2007, p. 515), and (2) there are serious questions as to whether the existing adversarial trial process and rigorous cross-examination are the appropriate ways to pursue a case involving an alleged sexual assault of a person with an intellectual disability (Benedet and Grant, 2012).

2. Competence to Marry

Marriage is a fundamental right guaranteed by the Fourteenth Amendment to the US Constitution (*Loving v. Virginia,* 1967; *Obergefell, v. Hodges*, 2015; see, generally, Perlin et al., 2008). It is viewed as such an important right in the United States that there is very little interference allowed by the states, although the state may impose reasonable requirements if they pose no significant interference with the marital relationship. By way of example, in *Turner v. Safley,* 1987, the Supreme Court ruled that a prison inmate marriage regulation that prohibited inmates from marrying other inmates or civilians unless the prison superintendent determined that there were compelling reasons to so allow it was not reasonably related to any penological objective. Substantial interference with the decision to marry is permissible only if important state interests are at stake and the regulation is closely tailored to effectuate the state's interests (id.). Marriage statutes have typically been created using "capacity" as a determinative factor, rather than "competency." Using an analysis of competency leads to a novel discussion that, so far, has not taken place in many laws or statutes.

Consistent with constitutional guarantees, the statutory requirements for marriage are minimal (e.g., *Mich. Comp. Laws Ann.*, § 551.103, 2007; *Tex. Fam. Code Ann.,* § 2.001, 2006). Every marriage requires capacity on the part of both individuals to enter into the relationship. (*Mahan v. Mahan*, 1956). This stems from the conception of marriage as a contract, as well as a social status (*Edmunds v. Edwards*, 1980).

3. Mental Capacity to Marry

As in other areas of civil law, individuals are presumed to possess capacity in the absence of a determination to the contrary (e.g., *Accounts Management, Inc., v. Litchfield,* 1998; see, generally, Perlin and Lynch, 2014). Moreover, a presumption of validity applies to marriages, reflecting the state's interest in promoting and protecting marriage and family (e.g., *Greathouse v. Vogsburg*, 1960).

The best accepted standard for mental capacity to marry is whether the individual understands the nature of the marriage contract and the duties and responsibilities it creates (e.g., *Estate of Hendrickson*, 1991). The language of this standard parallels the capacity standard for ordinary contracts, but the meaning is quite different due to the vast differences in the responsibilities and consequences of marriage as opposed to those stemming from engaging in ordinary business transactions (e.g., *Minn. Stat. Ann.,* § 517.01, 2006, establishing contractual capacity as applicable to marriage).

As one court described it:

> Marriage in many cases, depends more on sentiments of mutual esteem, attachment, and affection, which the weakest may feel as well as the strongest intellects, than on the exercise of a clear, unclouded reason, or sound judgment, of intelligent discernment and discrimination, and in which it differs in a very important respect from all other contracts. (*Johnson v. Johnson*, 1960, p. 14)

A Nebraska court quoted an early twentieth-century decision, phrasing it this way:

> Marriage is not a contract resembling in any but the slightest degree, except as to the element of consent, any other contract with which the courts have

> to deal, is apparent upon a moment's reflection. * * * What persons establish by entering into matrimony, is not a contractual relation, but a social status; and the only essential features of the transactions are that the participants are of legal capacity to assume that status, and freely consent so to do. (*Edmunds v. Edwards*, 1980, p. 425, quoting *University of Michigan v. McGuckin*, 1902)

Few cases specify what an individual must understand about the "nature of marriage" or the attendant "duties and responsibilities" in order to satisfy the marriage capacity standard. A contractual perspective would suggest that the material provisions of the marriage contract would define the understanding required for capacity to marry. Cases eschew such a formalistic approach, instead emphasizing the fact-specific nature of the capacity determination.

The formalistic approach was explicitly rejected in the case of *Ivery v. Ivery* (1963), involving a daughter's challenge to the marriage of her since-deceased father. The jury found that the father lacked capacity to marry, and the father's wife appealed. The Supreme Court of North Carolina reversed and ordered a new trial on the grounds that the jury instructions given by the trial court incorrectly suggested that marriage capacity required the ability to understand the applicable intestacy statute as well as the revocatory effect of marriage on wills predating the marriage. In other words, capacity to marry does not necessarily require an appreciation of the panoply of property rights of a surviving spouse.

As in the case of other capacity doctrines in the civil law, capacity to marry need exist only at the time of marriage (e.g., *Briggs v. Briggs*, 1958). Proof of a mental disability that ordinarily compromises the capacity to marry will not invalidate a marriage entered into during a "lucid interval" (*Mahan v. Mahan*, 1956, p. 547). This is another means by which courts can enforce the policy of preserving marriage, which is presumed valid, with the party attacking marriage being assessed the burden of proof (*Lott v. Toomey*, 1985).

4. Context and Standing

Claims of incapacity to marry arise in three basic contexts: (1) one spouse seeks annulment after a period of living with the other spouse as husband and wife; (2) a guardian or family member seeks annulment during the lifetime of the spouses; and (3) a guardian or family member seeks annulment after the death of one of the spouses. Not all of these claims are viable in all jurisdictions. Restrictions on who has standing to sue, the time in which the annulment suit must be brought, and the form of the suit vary by jurisdiction depending on statutes governing marriage, guardianship, and civil procedure as well as common law principles of standing, collateral attack of judgments, and other doctrines (see, generally, Perlin and Lynch, 2014).

i. Spouse Seeks Annulment

In general, one spouse may seek annulment of a marriage to the other spouse based on incapacity. In a few jurisdictions, however, only the spouse alleged to lack capacity may assert the claim; a competent spouse who wants to dissolve the marriage must pursue divorce (e.g., *N.Y. Dom. Rel L.*, § 140, 1999; *Wash. Rev. Code. Ann.*, § 26.04.130, 2005; see, generally, Perlin and Lynch, 2014).

Historically, annulment did not justify judicial rearrangement of the parties' property rights because alimony, property division, and community property all flowed from marriage. Annulment of the marriage would void it from inception, leaving no basis upon which to order spousal support, alimony, or division of property. While some jurisdictions adhere to the common law rule (e.g., *Williams v. Williams,* 2004; *Shoustari v. Zamari,* 2004), others have deviated from the common law rule in order to provide relief for the spouse requiring permanent maintenance (alimony) or property division (e.g., *White v. White*, 1984; *Callaway v. Callaway*, 1999).

Early cases reflect the advantage that annulment offered to a propertied spouse, as compared to divorce, where alimony and property division would otherwise be routine. In *Forbis v. Forbis*, a Missouri case decided in 1955, for example, Mrs. Forbis petitioned the court for separate maintenance after Mr. Forbis refused to permit her to return to their marital home following a stay in an insane asylum. Mr. Forbis responded to the claim by seeking annulment on the grounds of Mrs. Forbis's incapacity to marry. After observing that the presumption of validity of a marriage is "one of the strongest known to the law," the court affirmed the lower court's judgment awarding separate maintenance to Mrs. Forbis and denying Mr. Forbis's claim for annulment (id., pp. 807–09).

Before the advent of "no-fault divorce," annulment offered potential for relief for a spouse who had no grounds for divorce but did have grounds for arguing incapacity. In some cases, a decade or more elapsed between the marriage and the application for annulment (e.g., *DeMedio v. DeMedio*, 1969). In these cases, the spouse alleged to lack capacity to marry typically suffered from a chronic mental illness or other disability that predated the marriage. Courts usually refused to annul such marriages, invoking the "lucid interval" doctrine to refute the contention that chronic mental illness could itself establish incapacity to marry (e.g., *Larson v. Larson*, 1963).

Today, the availability of no-fault divorce eliminates the motivation to use one spouse's mental illness as a means of annulling the marriage where no grounds for divorce exist. The property motive for preferring annulment to divorce also has largely disappeared because many jurisdictions, recognizing the potential for unfairness, expanded courts' authority to order alimony or property division upon annulment. This development has decreased the incentive for a spouse to seek annulment rather than divorce (see *Callaghan v. Leonard*, 1978, pp. 391–92). The *Callaghan* court quoted from the New Jersey Final Report to the Governor and Legislature of the Divorce Commission, noting that liberal divorce laws or no-fault divorce rules tend to reduce the actions for annulment because annulment sometimes involved "embarrassing grounds" such as impotency or incapacity.

D. Guardian or Family Member Seeks Annulment During Spouses' Lifetime

In order for a guardian to maintain an action for annulment on behalf of the ward, the guardian must have that particular authority, either by statute or by court order (see, generally, Perlin and Lynch, 2014). Several jurisdictions have enacted statutes that specifically authorize guardians to petition for annulment on behalf of their wards (e.g., *Wyo. Stat. Ann.* § 20-2-101[d], 2013; *S.D. Codified Laws,* § 25-3-2, 1999). In most other jurisdictions, courts have concluded that the guardian's general authority includes the power to seek annulment on behalf of the ward (e.g., *Nave v. Nave*, 2005).

In a few cases, courts have based their decisions about a guardian's authority over a ward's marriage on their guardianship statutes' provision governing the effect of guardianship on contracts (e.g., *Knight v. Radmoski*, 1980; *Matter of Johnson*, 1997). Under this analysis, marriage, like any other contract executed after authority over the subject matter of the contract has been transferred from ward to guardian, is void. Without a specific reference to marriage in the guardianship statute, "contracts" could be interpreted more narrowly, applying only to ordinary business contracts. The difference between the capacity required for ordinary contracts and the capacity required for marriage would seem to justify the more restrictive interpretation of the statutory consequences of guardianship. Another factor weighing in favor of the narrower statutory interpretation, consistent with the ward's protection, is the policy favoring the least restrictive limitations on a ward's autonomy (see Perlin et al., 2008, Chapter 5, D2).

Courts have not missed these points; instead they have focused on protection of the ward. This approach is understandable in the context of *Knight v. Radmoski*, a case that involved the marriage of an institutionalized, severely brain damaged young man to his treating psychologist (1980, id., pp. 1212–14). The psychologist sought, but did not receive, the approval of her fiancé's father for the marriage. The father, who had previously been appointed conservator of his son's estate, had further sought appointment as guardian. On the same day the guardianship was approved, the son married the psychologist, and the two left the Maine institution to live in Colorado. Noting the severe harm that the marriage and the move had caused the ward, the court held that a guardian's approval was a necessary prerequisite to marriage and that marriage without consent is voidable. On this theory the guardian had standing to seek annulment, which the court granted (id., p. 1216).

E. Guardian or Family Member Seeks Annulment after Death of a Spouse

After the death of either party to the marriage, annulment may be unavailable (see, generally, Perlin and Lynch, 2014). Traditional legal theory allows suits after the death of a spouse if the marriage was void, but not if it was merely voidable (see, e.g., *In re Santolino*, 1985, concluding that the prevailing rule continues to provide that a void marriage may be annulled after the death of one of the parties absent a statute to the contrary. At common law, mental incapacity resulted in a void marriage, as did bigamy, incest, and other fundamental violations of public policy (Williston, 2003, § 1:2). Less serious defects in a marriage, such as fraud, resulted in the marriage being merely voidable (id.).

Today, several jurisdictions classify a marriage involving a spouse who lacked capacity to marry as voidable rather than void. Following the common law distinction between void and voidable transactions, classification of a transaction as voidable causes the action to abate after the death of either of the spouses (e.g., *Davidson v. Davidson,* 1967; *Nunley v. Nunley,* 1965). Some states specify by statute when and whether an annulment action abates (e.g., *Del. Code Ann.,* tit. 13, § 1506[b], 1975; *Mont. Stat. Ann.*, § 40-1-402[2], 2005). Where statutes do not specifically address the right to pursue annulment after the death of a party, a court may interpret other provisions of the statute governing annulments to prohibit such an action.

F. "Heartbalm Actions"

What about what are commonly known as "heartbalm actions"? Beginning in the early 1900s, courts became increasingly disinclined to permit recovery in tort for claims that emerged out of "tender matters of romantic or sexual emotion." Claims such as alienation of affection, breach of promise, or criminal conversation fell into disfavor under the weight of criticism that such claims were "anachronistic," resulted in excessive and unwarranted damage verdicts, and were used to extort or blackmail a marriage that was no longer wanted. Underlying much of the criticism was also the implicit belief that community mores had changed. Thus, for example, a failure to progress from engagement to marriage no longer carried the stigma that previously may have warranted a breach of promise action. As a result, a number of states enacted what are commonly referred to as "antiheartbalm statutes," which bar breach of promise and related cases and abolish the old common law claims (see, generally, Evans, 2005). Interestingly, the arguments that fueled the movement to abandon heartbalm torts were hardly consistent with the view that women were independent, competent people who did not need the law's protection. Instead, the main arguments in support of the antiheartbalm movement centered on women's alleged misuse of the torts to extort money from men, with newspaper articles calling plaintiffs in these cases "golddiggers" and "blackmailers" who used the heartbalm torts as tools for extortion (Pollard, 2007, p. 789, n. 116; see, generally, Perlin and Lynch, 2014).

Many laws surrounding marriage and divorce may appear paternalistic or stigmatizing, both to persons with mental disabilities and to women in general. The clear distinction between the two groups, which is acknowledged in the law, creates inequality and furthers stereotypes about the marginalized groups, painting them as incompetent in matters involving their personal decisions.

1. Issues of Statutory Rape

It is important to note that the case law and the theory that had developed around issues of marriage, divorce, and sterilization have developed totally independent from the case law and theory that have emerged in the area of the law of statutory rape (see Perlin and Lynch, 2014). A review of the relevant statutes and the case law reveals that not a single legislative committee that drafted any of these laws or the majority of a single appellate court that decided any of these cases ever gave the *slightest* thought to the issues that should be at the core of these inquiries (on the racial roots of many statutory rape policies, see Goodwin, 2013). Only two concurring opinions in two obscure state cases even "get" any of the key issues (on why legislators should modify the ways that defendants with intellectual disabilities may be charged with statutory rape, see Nevins-Saunders, 2012). We now address these issues.

i. Statutory Law. A typical statute is that of Alaska: It is sexual assault in the third degree to engage in sexual contact with a person that the offender knows is "incapacitated" or "mentally incapable" (*Alaska Stat. Ann.*, 2014, § 11.41.425[a][1][A] and [B]). Under state law, "incapacitated" means "temporarily incapable of appraising the nature of one's own conduct or physically unable to express unwillingness to act" (id., § 11.41.470[2]) (sounding as if meaning to describe someone who is seriously intoxicated or under the influence of drugs), and "mentally incapable" means "suffering from a mental disease or defect that renders the person *incapable of understanding the nature or consequences of the person's conduct*, including the potential for harm to that person" (id., § 11.41.470[4]).

In Alabama's similar statute, "mentally defective" is defined as meaning that "a person suffers from a mental disease or defect which renders him incapable of appraising the nature of his conduct" (*Ala. Stat.*, 2014, § 13A-6-60[5]). The New York laws are virtually identical (*N.Y. McKinney's Penal Law*, 2014, §§ 130.30[2], 130.00[5]).

Arizona defines the term with a bit more detail:

> The victim is incapable of consent by reason of mental disorder, mental defect, drugs, alcohol, sleep or any other similar impairment of cognition and such condition is known or should have reasonably been known to the defendant. For purposes of this subdivision, "mental defect" means the victim is unable to comprehend the distinctively sexual nature of the conduct or is incapable of understanding or exercising the right to refuse to engage in the conduct with another (*Ariz. Stat. Ann.*, 2014, § 13-1401[5][b]).

ii. The Case Law. An examination of the pertinent case law suggests that judges devote very little hard thought to the questions posed by these cases. Interestingly and somewhat surprisingly, the issue that emerges multiple times is a pair of *evidentiary* questions: What are the qualifications of an expert who testifies as to the victim's ability to consent, and when is such expert testimony needed at all? Most of the reported cases that look at the issues in any depth at all focus on this question. In a search of dozens of cases related to this subject, we found only two opinions, both concurrences, that seem to actually comprehend the scope of the issues involved. The cases that discussed these issues at all also seemed to deal with victims who were developmentally disabled, rather than mentally ill.

First, though, consider a 1950 case from Alabama, *Stephenson v. State. Stephenson* involved a case of sexual intercourse with a 27-year-old then-pregnant woman (stunningly, named in the opinion). After noting that it was "lack of mental capacity, and not lack of moral quality and strength" (id., p. 256), here is how the appellate court constructed the issue:

> We know and hear of people whose mental powers to perceive and grasp are impaired along certain avenues of thought and yet whose perception is

> fairly normal in other respects. *Lunacy implies a weakness or perversion of the mind, but not necessarily its destruction.* Idiocy, even, is generally accepted to consist in only a defect or sterility of the intellectual powers. The degree, of course, varies. (id., p. 258; emphasis added)

Mercifully, the modern cases mostly eschew this level of discourse.

Again, the bulk of the cases deal with issues of expertise, and all eventually affirmed convictions. A Washington case—after opining that "it has not even been shown that the psychiatric and psychological community is prepared to express an opinion on [the] issue of [whether the complainant was 'mentally incapacitated']" (*State v. Summers*, 1993, p. 956)—found that there was no reason to require expert testimony at all:

> Evidence that establishes a rape victim's inability to understand the nature and consequences of sexual intercourse is not the kind of technical evidence that requires medical testimony to decipher. Unlike evidence of command delusions, or medical malpractice, or the functions of computers, a witness' comprehension of the basic consequences of his or her actions can be proved or disproved from his or her testimony and testimony as to behavior. (id.)

There is no citation to any authority for this proposition.

A North Dakota case affirmed a conviction in which a social worker testified that the complainant was "a child in a woman's body, and that . . . [s]he is not capable [of giving consent], [as] she would not understand all of the social implications of this relationship" (*State v. Kingsley,* 1986, p. 830), although it noted that "expert medical testimony would have established a stronger case" (id.). A North Carolina case affirmed a conviction based on testimony of the assistant director of the county special education office that the complainant was "very limited . . . as far as being an adult" and was "very easily sidetracked" (*State v. Holley*, 2005, p. *2). A Massachusetts case affirmed a conviction in which a Division of Mental Retardation caseworker testified that the complainant "had the mental capacity of a nine-year-old child," without any predicate evidence of any testing ever having been done on her, concluding further that the question of consent "did not require any expert testimony concerning the specific etiology of any limitations relevant to her consent" (*Commonwealth v. Fuller*, 2006, p. 440). And a Utah case affirmed a conviction based on the testimony of a "mental retardation specialist" who was not licensed to *diagnose* mental retardation, reasoning that licensing was not "dispositive" of the expert's qualifications to offer an opinion on the victim's "ability to consent to a sexual relationship" (*State v. Kelley*, 2000, p. 550).

A New York case rejected the need for expert testimony in a case affirming a defendant's conviction of third-degree rape of a 33-year-old woman with intellectual disabilities (*People v. Cratsley*, 1995). In that case, the New York Court of Appeals (the state's highest court) carefully discussed the victim's abilities (and lack of abilities) as part of its case analysis:

> Complainant, Sherry K., was an employee of the Steuben Association of Retarded Citizens (ARC), a sheltered workshop that provided opportunity and support for adults who are mentally retarded. One . . . morning . . . she told her counselors—in accordance with her instruction on responding to sexual abuse—that she and defendant had engaged in sexual intercourse the previous weekend. In her own words, defendant had asked her to pull down her pants and, although she told him "don't do no more," he "put his go potty thing" inside her. Upon questioning, defendant, who was a cousin of Sherry K.'s stepfather, admitted the encounter, but insisted it was at her instigation and with her consent. According to testimony from her mother and stepfather, complainant had suffered brain damage at birth. She lived in an apartment attached to her parents' home, but was unable to cook for herself, handle money, perform anything other than repetitive tasks or cope with variation from her daily routine. She had a steady boyfriend with whom she went out to eat and visit acquaintances in the supervised community where he lived.

Found not capable of comprehending the nature of the oath, Sherry K. gave unsworn testimony. As her testimony revealed, she could not spell her last name or correctly state her age. While she knew the purpose of the birth control pills prescribed for her was to prevent pregnancy, she did not know what pregnancy was, or "where babies come from," and did not know about venereal disease (id., pp. 993–94).

Other cases fail to consider the ambiguities and difficulties presented by the operative statutes. An Indiana case, by way of example, found, tautologically, that the "plain and ordinary meaning" of "mentally disabled or deficient" in the state law was "subnormal intelligence or mental disease or defect" (*Douglas v. State,* 1985, p. 612). A Washington case—one that otherwise carefully focuses on the difference between individuals who "may have a condition which permits them to have a knowledge of the basic mechanics of sexual intercourse, but no real understanding of either the encompassing nature of sexual intercourse or the consequences which may follow" (*State v. Ortega-Martinez*, 1994, p. 237)—notes, without irony, that the complainant (whom the court found incompetent to consent to having sex) was *married* at the time (id., p. 233). A Georgia case, by way of contrast, specifically found that the fact that the victim had never been found to be legally incompetent did not mandate a conclusion that she was competent to engage in sexual activity (*Melton v. State,* 2006, p. 416). An Arizona case also considers whether the woman had "the capacity to understand the nature of her conduct" (*State v. Johnson*, 1987, p. 84), but fails to ever explicate what this means (that she might have a baby? That she might "feel good"? That she might have remorse?). The most bizarre of this set is an appellate case from California in which the court affirmed a conviction where the complainant was never sworn in as a witness but was permitted to answer questions—as to her age, her name, the spelling of her name—so that the fact-finders could "observe her behavior, her demeanor, [and] her actions" (*People v. Morgan,* 1987, p. 189).

Concurrences in two other cases demonstrate some grasp of the nuances of this difficult area of the law. In an Idaho case affirming a conviction (another case involving a married complainant), the majority quoted at length and with approval the trial court's observations that her answers to questions were "slow and short," and that her facial expression consisted of a "sagging jaw, mouth open" (*State v. Soura,* 1990, p. 115). Retorted the concurring opinion:

> I do not understand why the majority takes the time to relate anecdotal evidence of the victim's appearance in court in order to support the district court's determination that the victim could not legally consent . . . If I did not know better, I would have thought that the day was long gone when a person's intelligence was judged by a person's appearance (id., p. 116, Bistline, J., specially concurring).

In affirming the conviction, the majority had also gone out of its way to distinguish sex-within-marriage from sex-outside-of-marriage, pontificating that "non-marital sexual relations . . . are not considered by society in a favorable light because of the difficult consequences that may follow" (id., p. 114).

In another North Dakota case that affirmed a conviction, the concurring judges focused on the state's developmental disabilities rights law (the only such consideration of the rights of persons with disabilities in this entire universe of case law), noting:

> It is well to bear in mind that there is no presumption of incompetence simply because a developmentally disabled person is receiving special services or living at a residence for the developmentally disabled [citing state law]. Nor is a developmentally disabled person deprived of the right to "interact" with members of the opposite sex [citing state law]. I believe the State should, in cases like the instant one, present testimony of a medical expert on the subject of mental defect or mental disease and its effect on a particular individual's comprehension. The jury is entitled to at least that much,

> if not more assistance in reaching a verdict (*State v. Kingsley*, 1986, p. 831, Levine, J., concurring).

Again, *every one* of these cases deals with an individual with a developmental or intellectual disability. The only on-point case involving a complainant with a mental illness was a Michigan appeal, in which the court rejected the defendant's argument that "a psychological expert or an in-depth examination of the [defendant's] mental health records would have been helpful," noting cursorily that "it was established that the complainant was schizophrenic," and that, in conclusion, "there is nothing to suggest that more authoritative impeachment by an expert would have been of significant value" (*People v. Campbell,* 2008, p. *1).

Interestingly, there has been some recent excellent and thoughtful scholarship on the global issues related to statutory rape, some arguing—in the context of consensual teenage sex—that criminal penalties rise to the level of cruel and unusual punishment under the Eighth Amendment (see, e.g., Cohen, 2008; Oberman, 2004). Professor Elizabeth Nevins-Saunders has argued further that "punishing persons with mental retardation without regard to their awareness of the law, social cues, and the nature of their conduct may also run afoul of constitutional due process and proportionate sentencing principles" (2010, p. 1067). Yet, this has had virtually no impact on the case law in this area that reflects the ongoing infantilization of women with mental disabilities (see, e.g., Sabatello, 2010, p. 234, "women with disabilities have often wrongly and unfairly been seen as asexual objects, persons without 'normal' familial and sexual needs, or a mere burden on society").

G. Issues of Sterilization

1. Buck v. Bell

In 1927, in the course of a Supreme Court decision permitting the forced sterilization of a woman with a mental disability, Justice Oliver Wendell Holmes wrote famously, "three generations of imbeciles are enough" (p. 207; see Perlin and Lynch, 2014). Fifty years later, that court issued a series of decisions related to mental disability law, and legal scholars began examining previous decisions more carefully (see Perlin, 1993–94, p. 547). In 1976, Robert Burgdorf and Marcia Pearce Burgdorf compared *Buck v. Bell* to the "philosophical premises underlying Nazi atrocities" (p. 996). After this scathing analysis of the decision, more scholars and critics came forward, agreeing with the Burgdorfs that this decision was "an embarrassing example of bad law" (id.). It became clear that forced sterilization was no longer supported in the academic legal community.

The most important development in this area in recent years has been the publication of Professor Paul Lombardo's brilliant book, *Three Generations, No Imbeciles: Eugenics, the Supreme Court, and Buck v. Bell* (2008). *Three Generations,* finally and definitely, utterly discredited Justice Holmes's "chilling epigram" (Perlin, 1993–94, p. 539) in his infamous "three generations" opinion (on the political implications of sterilization decision making as well, see, e.g., Ng, 2012, discussing implications of China's policy of "quality births," leading to the sterilization of couples with mental disabilities; Chou and Lu, 2011). Professor Lombardo's work and other research of the past 30 years all demonstrate the utter lack of scientific basis for the conclusion that either Carrie Buck or any of her succeeding generations were "mentally defective" or "imbeciles" (e.g., Cynkar, 1981; Gould, 1985).

2. Misapplication of "Best Interests" Standard

The jurisprudence on sterilization in the United States, Australia, England, and Canada makes clear that decisions are "routinely made on behalf of girls and women with disabilities by their parents and care-givers, ostensibly in their 'best interests,' without considering whether their informed consent can be given" (Holness, 2013, p. 12), decision making that runs afoul of the guidelines of the International Federation of Gynecology and Obstetrics (FIGO) that require that laws should make the "free and informed consent *of the woman herself* a requirement for sterilization" (id., quoting FIGO, 2011). Professors John Tobin and Elliot Luke make a narrow exception, concluding that "where all reasonably available alternative measures have been exhausted, the sterilisation of a woman or girl who is incapable of providing informed consent will be justified where it is necessary to secure her right to health" (2013, p. 5).

In the United States, several courts have weighed state constitutional provisions along with their federal counterparts in cases involving petitions for involuntary sterilization of minors or incompetent persons, and they have found both the right to be sterilized and the right to autonomy in sterilization decision making to be protected by such provisions (compare Servias et al., 2004, discussing the high rate of sterilization of such women in Belgium, and noting the correlation between sterilization rates and institutional residence). There have been calls for comprehensive sterilization legislation to protect the privacy rights of women who might be otherwise sterilized against their will (see Fersel, 2014), but, such legislation has not been enacted.

The New Jersey Supreme Court, for example, first recognized that, although a right to sterilization had not received express constitutional protection from the US Supreme Court, several lower courts had found such a right. Drawing on its decision in *In re Quinlan* (1976), the right to be sterilized was included in the privacy rights afforded by the federal Constitution. Beyond this basis, the court specifically found that the right was also protected by the state constitution and that "the governmental intrusion into privacy rights may require more persuasive showing of a public interest under our State Constitution than under the federal Constitution" (*Matter of Grady*, 1981, p. 474). In the cases of women *seeking* sterilization, the American College of Obstetricians and Gynecologists (ACOG) has suggested that a "physician who objects solely as a matter of conscience has the obligation to inform her that sterilization services may be available elsewhere and should refer her to another caregiver" (Tazkargy, 2014, p. 160, quoting ACOG, 2007). Approximately 18 states allow for voluntary sterilization (Tazkargy, 2014).

There are still many cases litigated in which parents seek the sterilization of their daughters with mental disabilities (Stefan, 1989, pp. 413–27), and, in a disproportionate number of cases, women from lower socioeconomic strata are more highly represented in this cohort (Werner, 2012, p. 17; Chou and Lu, 2011). In one case, the California Supreme Court found that state legislation that absolutely forbade sterilization of persons under conservatorship deprived developmentally disabled persons of their privacy rights under the state and federal constitutions. The court also found the right of a woman "to choose whether or not to bear a child and thus to control her social role and personal destiny" was a fundamental right under the same state constitutional provision, which could be restricted only by a compelling state interest (*Conservatorship of Valerie N.,* 1985, p. 774; compare Stefan, 1989, p. 454, characterizing how sterilization may be seen as a perverse "vindication" of the reproductive rights of institutionalized women).

Other cases have discussed a circuit court's state constitutional right to rule on the petition of a guardian seeking to have an adult daughter with mental retardation sterilized, and they have found that a trial court of general jurisdiction had, pursuant to state constitution, broad *parens patriae* power over incompetent persons, enabling it to act on a petition seeking sterilization filed by the guardian of a noninstitutionalized adult mentally disabled woman with Down's syndrome (*Matter of Susan S.,* 1996). On the other hand, the Colorado Supreme Court held that there was no clear and convincing evidence to show that a woman with mental disabilities was unable to grant or withhold consent to sterilization, and the state constitutional law issue was thus not reached (*Matter of Romero*, 1990). In a later case, the Eighth Circuit found that, if proven, the allegations that state social service workers had compelled a mildly retarded woman to submit to a tubal ligation rose to the level of a due process violation (*Vaughn v. Ruoff,* 2002).

Scholars have also turned their attention to the rights of a person with mental disabilities to resist state-sponsored sterilization (e.g., Larson and Nelson, 1992; Marcus, 1991; Scott, 1986; Dugan, 1993), and the issues raised when a victim of such sterilization seeks compensation (West, 2013). In the context of international human rights law, Oana Girlescu concludes that forced sterilization is a per se violation of the United Nations' Convention on the Rights of Persons with Disabilities (2012). The latter conclusion makes even more shocking the recent Australian research that found that 23 percent of Australian doctors endorsed sterilizing males with intellectual disabilities and 41 percent endorsed so sterilizing females (Gilmore and Malcolm, 2014).

Sterilization, in some cases, may even be a "bargaining chip" as part of a plea arrangement. In a Louisiana decision, 78-year-old Frank Tullier agreed to carry out his surgical castration that was part of an earlier plea deal for eventual release back to the community. In the decision discussing Tullier's release, the trial judge in that case mandated that it was "time to give Caesar what Caesar is due" (discussed in Smith, 2013, p. 216, n. 22; see also Batchoo, 2007). Professor Heather Ellis Cucolo has discussed the "sanitization of sex" among the cohort of offenders in civil commitment settings. In addition to sterilization, there has been a recent increase in the recommendation of chemical castration in sex offender cases (e.g., Stinneford, 2006). She observes that we sanitize through administering drugs to chemically castrate individuals, as well as performing actual castration (Cucolo, 2007). Although consent issues rarely arise in these cases, the question of duress needs to be considered when offenders are told that these medications and procedures are their only hope for freedom and eventual release to the community. Even with castration, offenders are often still not viewed as candidates for release (Weinberger et al., 2005). And there are still cases in which ironically titled "Courts of Protection" continue to authorize the sterilization of disabled persons (Hewson, 2014).

The fear of individuals with mental disabilities who have committed sex offenses is twofold: Not only have they committed a particularly taboo offense, but there is the stigma and perception by society that, because of a mental illness, they are particularly sexually dangerous. Even the "sanitization" of their "out-of-control" sexual urges does not allow for their release.

All of this must be contextualized in the myths that have arisen about persons (especially women) with mental disabilities. Maya Sabatello tells us that "women with disabilities are . . . assumed to be a-sexual, sexually inactive *or else,* that their sexuality and fertility should be controlled" (2014, p. 258). Doug Jones notes that "the most significant myth is that women with disabilities are asexual" (2007, p. 223). Andreas Dimopoulos critiques the "social stereotype for persons with intellectual disability that they should not be having sex, that they should be asexual" (2012, p. 9); Rangita de Silva de Alwis focuses of the *vulnerability* of women with disabilities to "the imposition of social stereotypes of asexuality and passivity (2009, p. 296). And Amy Spady contradicts these stereotypes by asserting that many persons with mental disabilities experience the same, if not greater, sexual urges as other individuals" (2008, p. 56; see also, id.: "Sexual desire alone is not creative of a right to sexual freedom, but it does place value on the freedom to engage sexually"). As we discuss subsequently, it is stereotypes such as these that have so badly warped our social policies in this area.

H. Issues of Dementia and in Geriatric Facilities

Dementia is a brain syndrome characterized with disruptions in memory, orientation, judgment, executive functions, and communication with surroundings. The most common cause of dementia is Alzheimer's disease even though other brain disorders can also result in a diagnosis of dementia. Regardless the cause, impaired mental function within dementia syndrome is crucial for any assessment of legal capacity (Filakovic et al., 2011).

Individuals with such a condition or other similar neurocognitive disorders are often thought to lack capacity and are often consequently deemed incapable of providing valid consent to any kind of sexual behavior (Tang, 2015, citing Mayers, 1998). But scholars and some state legislatures now agree that it is necessary to balance the cognitively impaired individual's right to sexual expression with the societal interest of prohibiting illegal sexual conduct (id., citing Stavis, 1991). This is an especially knotty problem because of social attitudes that reflect "general discomfort with the idea of cognitively impaired elders engaging in sexual activity" (id., p. 451); this has resulted in an overall lack of laws, regulations, and general guidelines on the subject (Stavis, 1991; on the special issues involved in determining the capacity to consent to sex in this population, see Boni-Saenz, 2015; Drobac and Goodenough, 2015).

And the issues are even more knotty when those involved reside in nursing homes or other similar institutions. Professor Evelyn Tenenbaum sets out the issue clearly: "Nursing homes have difficulty dealing with intimacy and sex because they are central to life satisfaction and psychological wellbeing, but are also constricted by moral values and cultural expectations" (2012, pp. 459–60). In one infamous example, a nursing assistant discovered two elderly men having oral sex, separated them from each other, and transferred one to a psychiatric ward where he was subsequently put in restraints (Hovey, 2009, citing Cahill and South, 2002). Here, Professor Tenenbaum underscores that "health care professionals have difficulty accepting residents' rights to privately engage in sexual expression because of their cultural values, personal beliefs, and training, thereby complicating the development of management and treatment strategies" (Tenenbaum, 2012, p. 459, n. 1, quoting Borell, 2012). Older people regularly face discriminatory views about their sexuality from attending professionals (Gill, 2012; Bauer, 1999). Although this population has long been considered asexual in American culture (see, e.g., Langer, 2009; Walz, 2002), contrary to this cultural belief, older adults have been found to be sexual throughout life wherever they are living (e.g., Lindau et al., 2007; Miles and Parker, 1999; see, generally, Cornelison and Doll, 2012). This is a phenomenon even being noted in the popular press, including the *AARP Bulletin* (Scott, 2015).

Analyzing the state of the law, Stephanie Tang has found a "lack of consensus on the tipping point of when a state's interest in protection from sexual abuse should override the sexual freedom of an elderly individual" (Tang, 2015, p. 470), noting that some states have yet to deal with this issue and that other states have applied multiple tests of determining competency in this context thus leading to "high levels of speculation" as to the outcome of any case in which a person is criminally prosecuted for having sex with someone—even a spouse—who may have such neurocognitive impairments (id.). She thus has recommended the use of model assessment tools (such as the Socio-Sexual Knowledge and Attitudes Test (SSKAT) and Cognistat that employ a "clinical perspective to evaluate a person's capacity to consent to sexual activity" (id., pp. 483–84; the tests are discussed in Niederbuhl and Morris, 1993, and in ABA Comm'n on Law and Aging and Am. Psychol. Assn., 2008). To this end, J. Richard Lindsay has recommended that states should adopt specific legislation that gives facilities "clear choices of approved methods for determining sexual consent capacity" (2010, p. 306).

Several years ago, Professor Tenenbaum suggested that a patient's current needs for sexual expression and intimacy should be balanced against any "previously formed critical interests" (2009, p. 717). In a more recent piece, she changed this balance somewhat, and now argues that the patient's "current experiential interests in continuing his intimate relationship should generally receive greater weight" (Tenenbaum, 2012, p. 477) "when the patient is involved in a stable, on-going sexual relationship that provides continuing gratification" (id., p. 488). She quotes Steven Miles and Kara Parker—"To humanize nursing homes, we will have to humanize our own perceptions of the people who live in them" (1999, p. 41)—and adds, "An important step in this direction is to respect their vital interests in intimate relationships" (Tenenbaum, 2012, p. 467). Along the same lines, a relatively recent law review article made an observation that has gotten surprisingly little attention:

> Not only will the sheer number of new nursing home residents likely increase substantially in the next few decades, but many of those future residents came of age during the sexual revolution of the 1960s and 1970s and possess vastly different attitudes toward sex than their conservative parents. (Hill, 2014, p. 473; see also, Thornton and Young-DeMarco, 2001).

Writing with a coauthor about shame and humiliation in the law, one of the coauthors of this book (MLP) focused on the humiliation that is often globally shared by institutionalized elderly persons (Perlin and Weinstein, 2014; see Liang, 2006, discussing the shame nursing homes frequently cause). There is no question that the ways that sexual intimacy is dealt with in many such facilities contributes to these levels of shame and humiliation.

One relevant case made national news earlier this year. There, a 78-year-old man was arrested and charged with sexual abuse for having sex with his wife who was institutionalized in a nursing home because of dementia, posing the question, "When is a previously consenting spouse suffering from dementia no longer able to say yes to sex?" (Kaplan, 2015). Although the defendant was ultimately acquitted by a jury (see Belluck, 2015), the prosecution can certainly have a chilling effect on others—both in and outside of institutions—who seek to exercise their sexual autonomy. This prosecution also likely "plays into" a specific set of social attitudes captured perfectly by Daniela Franco and her colleagues: "Sexuality is . . . acceptable for people as long as it does not involve their grandparents, parents, children or siblings" (Franco et al., 2012, p. 283; see also Brodoff, 2010, p. 286: "Often the people who do take issue with a developing romantic relationship are the adult children of a parent with Alzheimer's disease").

I. Issues Related to Locus of Institutionalization

We have, up until this point, generally spoken about issues in psychiatric hospitals. However, equally prevalent are those issues arising in facilities for individuals with developmental disabilities, and it is important to provide context for how these types of facilities may differ.

In our subsequent discussions of institutional dilemmas regarding the expression of sexuality and sexual autonomy, it is important to keep in mind that the term "facility" or "institution" can refer to a wide range of places. We will discuss psychiatric hospitals, group homes, assisted-living facilities, nursing homes, jails, prisons, and homes for individuals with intellectual/developmental disabilities. Each of these types of facilities can create its own unique policy and caters to a particular population.

Generally, there is a clear distinction between a facility for an individual with mental illness, like a psychiatric unit in a hospital, and a facility for an individual with a developmental disability. While dual-diagnosis units and living spaces are becoming more popular, especially as the incidence of dual diagnosis rises, there does remain a separation between the two populations in terms of facilities designed to house them when they are not able to live in the community.

Individuals with developmental and intellectual disabilities generally live in the community, with family, or in group living situations. Historically, this has not been the case, and still today, there are many who reside in distant, impersonal institutions. Just 20 years ago, many more individuals with developmental and intellectual disabilities lived in contained facilities specifically designed to house these individuals. Often referred to as "developmental centers," they provided housing for individuals of all ages and with all types of developmental and intellectual disabilities. However, based on legal doctrine like the *Olmstead* decision and the uncovering of extraordinary abuses of individuals in developmental centers like Willowbrook in New York, many states have moved to close most or all of their developmental centers.

Individuals with mental illness generally will not live in developmental centers. Instead, depending on the nature and severity of their illness, they may also live in the community, in a group home, in communal apartments or be admitted to a psychiatric hospital either voluntarily or involuntarily.

The most restrictive setting is the psychiatric unit or hospital. Individuals there are either held involuntarily, because a judge has found that they are a danger to themselves or others based on their mental illness, or have agreed to stay voluntarily and seek treatment. Unlike years past, individuals with mental illness do not permanently live in these facilities. In fact, since the large push for deinstitutionalization, it is more and more common for individuals to have shorter stays and then be placed in a less restrictive setting like a group home, apartment, or independently in the community. However, stays can still be several weeks or months, depending on a number of factors. During the time that an individual is in the hospital, whether he is there voluntarily or involuntarily, he is required to follow the policies set up by the hospital. This includes any policies about sexual activity in the units.

Differences may also be present in the types of policies established that allow for, or ban, sexual activity between residents of these facilities. Each population has its own stereotypes and biases working against it, and those are reflected back in facility policies that may look different depending on the facility type.

1. Cases Involving Persons with Intellectual Disabilities

Suzanne Doyle states the issue clearly:

> Although the last two decades have seen the application of the social model of disability transform societal perceptions of disability, the issue of sexuality and sexual behaviour, particularly for persons with intellectual disabilities, has not been subject to the same level of debate and advocacy. (Doyle, 2010, p. 113)

American society is uncomfortable when confronting the sexuality of persons with intellectual disabilities, especially when they are institutionalized (see Denno, 1997, p. 324, noting that social service providers frequently segregate males and females in institutions or residential homes for persons with intellectual disabilities, in part "because of outmoded perceptions of their sexuality"). As Professor Denno notes: "Among the 'psycho-sexual rules' that society applies to all individuals are two that pertain specifically to mentally retarded persons: (1) they should not be sexual; and (2) they should not be allowed 'psychosocial-sexual expression and especially sexual intercourse'" (id., p. 338, quoting Monat, 1982, pp. 58–59). Most recently, a survey of Australian doctors found that, in the aggregate, that group viewed less sexual freedom as desirable for adults with intellectual disabilities compared with adults in the general population (Gilmore and Malcolm, 2014).

In this context, *thinking* about sexuality and persons with mental disabilities "forces us to consider the extent to which rules that appear intended to protect individuals with mental disabilities by limiting or subordinating their sexual autonomy are actually the product of a patronizing paternalism toward persons with mental disabilities in institutions" (Perlin, 1993–94, p. 520). "No sex" policies also fly in the face of the valid and reliable research that teaches us that persons with intellectual disabilities "can be educated to understand what is and is not appropriate sexual conduct" (Nevins-Saunders, 2010, p. 1096). And we have known for years that policies suppressing sexual behavior may lead to antisocial behavior, added aggression, and poorer social adjustment (Denno, 1997, p. 392, n. 472, citing, inter alia, Brantlinger, 1987, p. 179; Money, 1973, p. 3; R. R. West, 1979, p. 11).

As Doyle perceptively notes, "The treatment of people with intellectual disabilities' sexuality epitomizes society's past marginalization of the lives of persons with disabilities generally" (2010, p. 113). And although experts in the field of intellectual disabilities generally agree that intellectually disabled persons have a fundamental right to sexual expression (Reed, 1997, p. 805, citing Fegan et al., 1993), as discussed above, the reality is that that right is often denied and that institutional residents who choose or seek to act upon it are punished (see Deisher, 1973, pp. 148–49, reporting that 12 percent of caregivers would punish institutionalized persons with disabilities for masturbating, 65 percent would not allow heterosexual behavior except that which was solely of a social nature, and 50 percent would stop clients from kissing and hugging).

As we discuss subsequently (see below, at pp. 112–115), the denial of the right often is articulated—improperly, we believe—as flowing from the desire to protect vulnerable people (Quinn and Happell, 2015b, citing Dyer and McGuinness, 2008; Hales et al., 2006).

2. The Effects of Institutionalization on Persons with Disabilities and Sexual Autonomy

i. Patients in Civil Hospitals. Next, consider the practical implications of sexual relationships in a closed institution like a psychiatric hospital (see Perlin and Lynch, 2015b). Under the best of circumstances, entering into a new sexual relationship can be stressful and confusing. Are these stresses "inappropriately" exacerbated when the universe in question is that of institutionalized mental patients? To what extent should the differing stress management abilities of institutionalized individuals be factored into any policy ultimately adopted? Conversely, can preoccupation with sex systemically distort all matters involving ward behavior? How does this focus affect questions of individual versus group needs? Might an excessive concern with sex blunt the consideration of other related issues, such as self-esteem, the importance of developing a full range of interpersonal relationships, and the ability to deal with intimacy (see Perlin, 1993–94, pp. 524–25)? And again, we need to begin with the reality that, while sexuality is a fundamental and complex aspect of being human, affecting all areas of life and health, "it is largely neglected in health care, particularly in the care of clients with mental illness" (McClure, 2012, p. 711). And, importantly, clinicians continue to be "reluctan[t] to address sexual issues in clinical practice" (id., p. 713).

We impose significant barriers that prevent institutionalized persons with mental disabilities from establishing intimacy; notwithstanding the fact that the human need for intimacy is widely accepted (id.), caregivers simply do not appreciate the "fundamental importance of intimacy to consumer well-being" (Tennille and Wright, 2013, p. 9). Yet, one study showed that most patients in *high-security* hospitals "valu[ed] being in a caring relationship [while] in the hospital" (Hales et al., 2006, p. 260) and that there was likely "an ongoing desire for intimacy regardless of gender, diagnosis or offense group" (id.). Although the ethicist Jacob Appel has argued that sexual relationships between institutionalized individuals "ought to be *encouraged*" (2010, p. 153, emphasis added), there has been little support for this position ever exhibited by institutional staff or administrators.

A closed institution, by its nature, places substantial limits on individuals' mobility and freedom of action. In considering how best to allow individuals to express their autonomy, it is important to consider all aspects of a relationship, including issues indirectly raised by sexual intimacy. Of course, although sexual behavior is usually seen as private behavior in mainstream society, it inevitably becomes a "public/social issue in the context of institutionalization" (Gill, 2012; McGauhey and Tewksbury, 2002, p. 135). For example, when people in the "free world" terminate a stormy love affair, frequently they can adjust their lives so as not to have much contact with their former lovers. What happens if that ex-lover lives on the same floor of an inpatient hospital (especially if it is a locked-ward hospital), and neither patient can leave without a court order? Conversely, what happens when a couple is split up by a court order transferring one patient to another ward or facility for clinical or legal reasons (Perlin, 1993–94, p. 525)? The latter consideration is made more complicated by decisions such as *Kulak v. City of New York* (1996), holding that no liberty interest is created by a court recommendation that a mental hospital transfer an involuntarily committed patient to a less restrictive environment because such transfer was not mandatory.

In any event, can patients be stopped from having sex? The valid and reliable research tells us that hospital rules do *not* prevent sexual activity from occurring (Quinn and Happell, 2015a, citing Higgins et al., 2008; Welch and Clements, 1996), and one study—in a facility with a "no sex" policy—reported that 30 percent of patients were sexually active (Quinn and Happell, 2015, citing Warner et al., 2004). This, of course, all leads to patients hiding their relationships from their caregivers, a gambit that may further negatively affect their recovery (Quinn and Happell, 2015b, citing Perlin, 2008b). Significantly, researchers continue to be *surprised* when they learn that patients are sexually active: "Incidents of sexual behavior are remarkably common in acute psychiatry" (Bowers et al., 2014, p. 278).

These are all issues that must be considered in order to allow individuals confined in an institution the ability to engage in a relationship just as they would in the "free world." Although an institution may need to restrict some privileges based on safety or treatment concerns, it will be critical for institutions to consider a "least restrictive environment" approach when dealing with patients' sexual autonomy, as it is undoubtedly part of their rights under the CRPD (see above, Chapter 3, III.A).

Another series of issues to consider comes from differences in the status of institutionalized persons (see Perlin, 2010b, discussing, in the context of questions involving the right to refuse treatment, the significance of patients' "litigational status"). Those institutionalized after being civilly committed, ordered confined for a competency evaluation, or held in a locked facility after a plea of not guilty by reason of insanity each have rights and aspects of law that are unique to each particular status. Assuming the individuals wishing to engage in sexual activity are competent to consent, are all patients to be treated in the same way, or are there differences between voluntarily and involuntarily committed patients that are relevant to this inquiry? Further, should involuntary commitment implicitly restrict one's freedom to engage in sexual activity? Is it justifiable, or even legally required, to place different restrictions on patients who have been committed following their involvement in the criminal justice system, in comparison to those imposed on civilly committed patients? If competency to consent is not at issue, disallowing sexual activity solely based on legal status appears punitive, rather than therapeutic.

ii. Patients in Forensic Hospitals

a. Introduction. Remarkably (or perhaps not so remarkably), there is virtually no law on the books that deals with the precise topic of the sexual autonomy rights of persons institutionalized in forensic psychiatric facilities (mostly those awaiting incompetency-to-stand trial determinations, those found permanently incompetent to stand trial, those who had been acquitted by reason of insanity, and, in some jurisdictions, individuals transferred from correctional facilities), a population that remained the most hidden (see, generally, Perlin and Schriver, 2013; Perlin, 2008b). Some American jurisdictions have enacted "patients' bills of rights" providing a broad array of civil rights and liberties for persons institutionalized in psychiatric hospitals (see Perlin and Cucolo, 2015, § 7-3.1.8) Most of these laws flow from the historic and monumental decision of *Wyatt v. Stickney* (1972), *Wyatt v. Aderholt* 1974), which found a broad-based right to treatment for institutionalized mental patients (id., 1972, p. 381).

As discussed earlier (see Chapter 3), despite this ruling, only a few jurisdictions follow the lead of *Wyatt* and mandate a limited right to sexual interaction (e.g., *Mont. Code. Ann.,* 2005, § 53-21-142[10]: "Patients have the right to be provided, with adequate supervision, suitable opportunities for interaction with members of the opposite sex except to the extent that a professional person in charge of the patient's treatment plan writes an order stating that such interaction is inappropriate to the treatment regimen"); *Ohio Rev. Code Ann.*, 2000, § 5122.29(I) (guaranteeing a patient's "right to social interaction with members of either sex, subject to adequate supervision, unless such social interaction is specifically withheld under a patient's written treatment plan for clear treatment reasons"). In at least one of these jurisdictions, there are limitations for forensic patients (see *Ohio Rev. Code Ann.*, 2000, § 5122.01[C][(1] and [2]); typically, forensic patients are afforded fewer civil rights in all aspects of institutional life than are civil patients, and they are generally housed in facilities that provide less personal autonomy (see Perlin and Schriver, 2013). Of the important post-*Wyatt* cases, forensic patients were part of the plaintiff class only in the Ohio case of *Davis v. Watkins* (1974, pp. 1201–2). Much of the case law ignores forensic patients entirely. There is no dispute that, as controversial as sexual issues are in all mental health services, it is "more so" in forensic services (Quinn and Happell, 2015, p. 127; see also, Bartlett et al., 2010; Dein and Williams, 2008).

A recent study of forensic hospitals in Europe found that no nation there has a national policy on sexual expression by forensic patients (Tiwana et al., 2015), noting that informal policies range from total prohibition (UK) to the sanctioning of sexual relationships with other patients and members of the community, including prostitutes (Netherlands).

b. "Deeper" Social Policy Issues Endemic to Forensic Patients. There are multiple issues of social policy embedded in this discussion that contribute to the paucity of attention paid to these issues that we now address. There are clusters of issues that are particularly pertinent in the cases of forensic patients: (1) those that flow from societal fears of persons whose connection to the mental health system originates from involvement in the criminal justice system; (2) the ways in which those fears have led to societal short-sightedness in our approach to these problems; and (3) the rights that such patients have, in spite of these social attitudes.

Fears about patient sexuality emanate from stereotype-driven misperceptions about patients' dangerousness, from worries about a public backlash, and from long-documented overreactions on the part of hospital administrative staff to the specter of litigation. The assumption, of course, is that patients in forensic hospitals are more dangerous than those in civil hospitals and, perhaps directly as a result of this assumption, are less "worthy" of having "privileges," and/or require greater social control (on the question of "privileges" in related areas, see Glensy, 2005, p. 118: "Perhaps because of its empowering nature, throughout the centuries, individuals and governments have persistently tried to deny liberty to others, either indiscriminately or by picking and choosing categories of people whom are deemed worthy or unworthy of enjoying its privileges.") But this attitude—which appears to be nearly universal—is based on an assumption that such patients are more dangerous than the norm. In many jurisdictions, if a patient is involved in any way with the criminal justice system, he or she is automatically housed in the most secure forensic facility no matter the underlying charge or his individual risk assessment (Perlin, 2000b, pp. 201–2). This administrative decision—one that is rarely noted and even more rarely challenged (see, e.g., *Hubbard v. State*, 1991; *Moten v. Commonwealth,* 1988)—creates a systemic bias as to all forensic patients, improperly eliminating the need for individualized risk assessments, a bias clearly infected by political values (see Dwyer, 2007, p. 783: "Policy and risk assessment [have] became concerned with political as opposed to individual risk factors").

J. Issues of Risk

The denial of the right to sexual autonomy often is articulated as stemming from the desire to protect vulnerable people (Quinn and Happell, 2015a, citing Dyer and McGuinness, 2008; Hales et al., 2006). Andreas Dimopolous responds directly to this purported justification: "By seeking to avoid harm to self we are perpetuating oppressive social and legal responses which presented persons with disabilities as asexual, or worse still, as individuals who *should be* asexual" (2012, p. 8; emphasis added). Certainly, our policies fly in the face of the concept of "dignity of risk" articulated first more than 40 years ago by the advocate Robert Perske (Nevins-Saunders, 2012, p. 1474, quoting Perske, 1972, pp. 194–95). As Gerben DeJong has stated the issue: "The dignity of risk is the heart of the [independent living] movement. Without the possibility of failure, the disabled person lacks true independence and the ultimate mark of humanity, the right to choose for good or evil" (Gross, 2003, p. 28, quoting DeJong, 1983, p. 997).

Courts are sharply divided on the question of how competence to consent to sexual activity should be determined. As Clarence Sundram and Paul Stavis have noted, some courts require not only an understanding of the nature of sexual conduct, but also an appreciation that there are moral dimensions to the decision to engage in sexual conduct. Others (the majority) require a showing that the person could understand the nature of the sexual conduct and the possible *consequences* of that conduct (e.g., pregnancy, disease, etc.), whereas the New Jersey Supreme Court (see *State v. Olivio,* 1991) has required only an understanding of the sexual nature of the act and a voluntary decision to participate, and has made it clear that an understanding of the risks and consequences of the act is not required (Sundram and Stavis, 1993, p. 450; on the significance of *emotion* in a determination of competence to consent, see Charland, 1988).

The "risks" may be legal as well as emotional. Ironically, in Ireland—a nation that just sanctioned gay marriage—it is a violation of the criminal law for two persons with intellectual disabilities to have sex outside of marriage (Finlay, 2014). One interpretation of state criminal codes in the US concludes that, in *45* jurisdictions, "*any* consensual sexual activity involving a person with cognitive impairments [is rendered] unlawful" (Wacker et al., 2008, p. 91, emphasis added). We endorse Professor Elaine Craig's observation that "[s]ocial approval is not an equitable basis upon which to criminalize particular sexual activities" (2014, p. 117), as well as the conclusion by Professor Julia Wacker and her colleagues that current laws "prolong a shameful history of segregation and social control of people with intellectual impairments" (Wacker et al, 2008, p. 93).

K. "Other Questions"

In addition to the specific competency questions discussed previously in this chapter, there are other questions that may emerge that require an inquiry into the competency of a person with mental disability to engage in other sorts of sexual acts. We are merely listing these subareas here as there is neither case law nor scholarly literature that has yet addressed these issues. We are confident, however, that, in the future, they will be the subject of both litigation and academic attention. They include, but are not limited to, consensual incest, sexting, and bestiality.

1. Consensual Incest

It will surprise many readers in the United States to learn that consensual incest is *not* a crime in many nations (mostly in Central and Eastern Europe) (Hörnle, 2014). In a recent article, Professor Tatjana Hörnle has argued that "*if both partners in a sexual encounter have given valid consent, a critical analysis must lead to the conclusion that criminal prohibitions are not bolstered by convincing reasons*" (id., p. 76).

Interestingly, in the leading European case on this subject, a question of mental capacity was, in part, before the court, in a case involving a defendant in Germany (where incest is a crime) convicted of having sex with his younger sister (of whose existence he was not aware until he was an adult and she was 16). The defendant was sentenced to 30 months in prison, but his sister (who was also convicted) received no sentence as the court found her to be "a timid, dependent young woman with a light mental disability that was found to reduce her culpability" (id., p. 80). Although the German Federal Constitutional Court found the law to be constitutional, it also found that such laws interfere with liberty rights, and, that, in the case of prohibitions concerning sexual behavior, these are the rights that protect the most private, intimate sphere of liberty. However, the Court found this did not require "absolute protection" if the legislature found certain conduct to be "particularly socially harmful and its prevention urgent" (id., pp. 80–81, discussing *B. v. R.*, *2008,* relying, in part, upon German Constitution, art. 2[1]). The defendant then appealed to the European Court of Human Rights, claiming that his criminal convictions interfered with his right to respect for his family life (*European Convention on Human Rights,* art. 8[1]), which affirmed the conviction, noting that, while it *did* interfere with his family life rights, such interference was permissible because of the "pressing social need for the measure in question" (*Case of Stuebing* 2012, nos. 55–58).

Prof. Hörnle, in finding the latter decision "particularly unsatisfactory" (2014, p. 83) has recommended this standard:

> Once a person is over age and does not suffer from a well-defined (or well-enough-defined) mental illness or personality disorder as acknowledged in forensic psychiatry or psychology, she or he usually is seen as competent enough to give not only factual but also valid consent. For adult incest, one might thus assume that factual consent is per definition valid. (id., p. 88)

Very few litigated US cases deal with this question in the context of a party with a mental disability. In one case, however, in which a conviction that had been entered upon guilty plea was ordered be vacated "in the interest of justice," and the defendant (a 16-year-old who was the uncle of the 13-year-old other party and committed a "consensual act") to be adjudicated a youthful offender, the court noted that the defendant "was of limited educational and mental aptitude" (*People v. Lyman "HH,"* 1995).

In short, mental status issues appear now to be on the periphery of this question. It is not unreasonable to think that they will come more to the forefront in the future.

2. Sexting

Juveniles who voluntarily participate in "sexting"—sending sexually explicit photographs and messages via cellular phones or over the Internet *(Miller v. Skumanick,* 2009, p. 637)—are frequently prosecuted under state child pornography laws. In this context, the use of child pornography law has been variously described as "haphazard, outdated, draconian, nonsensical, foolish, outrageous, and unjust" (Birkhold, 2013, p. 899). Most scholars agree that the "criminal justice system is not the appropriate venue for confronting the problem of teenagers sexting each other" (Hessick and Stinson, 2013, p. 22, quoting Fradella and Galeste, 2011, p. 440); Professor Carissa Byrne Hessick concludes that "when there is no link between an image and such exploitation or abuse, ordinary First Amendment principles ought to apply" (2014, p. 1484).

Although, to the best of our knowledge, this issue has never arisen in the context of a psychiatric institution or a facility for persons with intellectual disabilities, this is not to say that it will never happen. Many hospitals ban the use of cell phones entirely;[6] others place stringent limitations on their use (Western Health and Social Care Trust, 2014). But that is not to say that patients do not have such phones, nor is it to say that juvenile patients do not have them. We can expect this issue to emerge often in the future.

3. Bestiality

Traditionally, bestiality was defined at law as the carnal copulation of man (or woman) with animals, or, as the Arizona Supreme Court said, somewhat floridly some seven decades ago, "a connection between a human being and a *brute* of the opposite sex" (*State v. Poole,* 1942, p. 47). The act was criminalized, in large part, because it was believed that "inhuman creatures could be produced by successful copulation between humans and animals" (Backer, 1993, p. 41, n. 11, citing Oaks, 1979–80, p. 38). Bestiality prosecutions appear to be fairly rare; a WESTLAW search has revealed only a handful of relevant cases from this decade (e.g., *State v. Coman,* 2012; *State v. Venes,* 2013), and most involve the sales and distribution of movies depicted sexual acts between humans and animals (see, e.g., Calvert and Richards, 2005).

Bestiality has been considered a sin—in fact, "the most grievous" sin—at least since Sir Thomas Aquinas so characterized it in the thirteenth century (Aquinas, 1265–1274, trans. 1922, q. 154, art. 12, p. 12), although the proscription dates to the Old Testament (Leviticus 18:23)—and this has been repeated regularly in the intervening millennia. And judges or state legislators have never questioned this seriously. But Professor Kent Greenawalt has offered these thoughts on this precise topic:

> Suppose a legislator thinks that bestiality is definitely a sin and probably has adverse psychological consequences for human participants. In deciding whether to vote for criminalization, the legislator should not count his simple judgment about sin; rather, he should ask if the likely adverse consequences are sufficient to justify making the behavior a crime. It is possible that if he performs this exercise conscientiously, he will see that the legitimate reasons for voting to criminalize are weaker than he initially thought, that if he discounts his "pure" judgment of sin, he does not believe the probable consequences are damaging enough to warrant a prohibition. (2007, p. 489)

Although it is "under the radar" for most, the question posed by Professor Julie Peakman—"can sex with animals be considered out of bounds?" (2013, p. 180)—is one that is being tentatively reevaluated. Those who identify as "zoos," having a sexual orientation toward animals, have "begun to create a distinctive sexual identity and to form an international community" (Cassidy, 2009, p. 91). "Bestial advocates argue that there should be a possibility of accepting cases of shared affection between humans and animals, where boundaries can be crossed" (Peakman, 2013, p. 206).

Most recently, writing in the journal of *Animal Law,* Antonio Haynes has explored this issue, concluding that a categorical ban on bestiality should be "eschew[ed]" and replaced with "a contextual approach grounded in assessing the level of apparent coercion" (2014, p. 128).

The relevance of Haynes's article to the subject matter of this book becomes apparent in his discussion of the meaning of "consent." He rejects the argument that, because informed consent can never be accurately obtained from an animal, bestiality is thus always impermissible (id., p. 135), in this manner:

> Vulnerability, however, cannot form the basis for permanently ruling out the ability to give consent to sex. If it did, then humans with intellectual disabilities would be permanently denied the ability to consent to sex. Some courts, recognizing this conundrum, have "refused to 'adopt the fiction that all persons are mentally or judgmentally equal'" but also would not "presume that a mentally retarded person was incapable of consent to sexual intercourse." Instead, such courts must determine whether the victim is able to "appraise the nature of the stigma, the ostracism or other noncriminal sanctions which society levies for conduct it labels only as immoral even while it 'struggles to make itself articulate in law.'" This is a sleight of hand, because the appraisal prong means that the intellectually disabled are "held to a higher consent standard than their nonretarded counterparts," whose ability to consent is not predicated on demonstrating an ability to weigh potential social fallout should their sexual behavior become known. This double standard, which requires people with intellectual disabilities to reach a higher bar for consent than that asked of their non-disabled counterparts, is widespread: all but nine states have some sort of explicit judicially-created test to determine if a person with impaired intellectual functioning can consent to sexual activity. Functionally, therefore, these rules, and others like it, constitute "legally enforced celibacy for mentally retarded persons and overzealous moralizing about who can and cannot engage in sexual relations." The result is a tremendous denial of the intellectually disabled person's dignity. (id., pp. 135–36, quoting, in part, Denno, 1997, pp. 343–47)

Haynes's analysis forces us to consider—in this very pointed and controversial context—the ways that we assess consent in the cases of persons with disabilities who wish to have sex with others (humans). Of interest is this: We have been able to locate just one recent and unreported case involving a bestiality prosecution of a person with mental disabilities. In Victoria, Australia, in the case of a 67-year-old man convicted of performing "lewd acts" with his horse, as a result of which he was sentenced to a community corrections order that he participate in offender behavior programs, a report before the court had suggested that the defendant's "autism may have impaired his judgment," the trial judge noting, "It's highly likely if he had have gotten the services he's getting now he might not have reoffended." (Gannon, 2015)

To some extent, this case echoes the decision in the *Lyman "HH"* case in New York, discussed above in the section on consensual incest: The sentencing judge understood that the defendant's mental disability played some role in the criminal act (although there was never an issue of competency to stand trial or the potential applicability of the insanity defense in either case). We believe that these approaches need to be kept in mind when we consider all of the other substantive issues in this work.

VI. Conclusion

As this chapter should make clear, the observation by Professor Loren Roth and his colleagues nearly 40 years ago—that the search for a unitary test of competence was like a "search for a Holy Grail" (Roth et al., 1977, p. 283, as quoted in Perlin, 1991a, p. 113) —resounds today when we inquire into "competence to have sex." It is not enough to say that this is a difficult and multitextured issue (which it is); we must also acknowledge that our social values, our prejudices, our stereotypes—our sanist and pretextual use of heuristic reasoning and false "ordinary common sense"—so dominate our thought processes as to make so many of our policies utterly incoherent. We hope that this book will help, to a modest extent, remedy this situation.

4

Social Policy Issues

I. Introduction

There are multiple issues of social policy embedded in this discussion that contribute to the paucity of attention paid to these issues that we now address. These range from the most personal of issues (masturbation, reproductive rights, abortion) to issues that necessarily involve institutional policies that implicate others' interests as well (impact of drugging side effects, sex education, right to sexual surrogacy services) to issues that implicate other areas of the law (torts and administrative law).

Before we take up these issues, however, we need to return our focus briefly to the question of *fear*, and the inevitable *denouement* of our *failures* to restructure all of the policies in question. In the prior chapter, we discussed fear in the context of hypersexuality (leading to repressive sterilization and no-sexual-contact policies). But we also need to briefly consider the always-present fears of adverse publicity and potential tort litigation that help drive the policies in question. In addition, we need to acknowledge how our head-in-the-sand policies lead to epic failures—failures to acknowledge how these policies diminish the likelihood of patient adjustment to the "free world" once released, how they ignore the tensions between freedom of action and potential coercion of others, and how, remarkably, they often ignore what it is that we really mean by "sex." Finally, our policies—that largely ignore the constitutional and statutory rights to which all patients are entitled (see Chapter 3)—also fail to take into account the disconnect between these rights and uninformed public opinion and to develop strategies to deal with this disconnect.

II. Fears, Failures, and Disconnects

A. The Heightened Fear of Adverse Publicity on the Part of Institutional Administrators if They Were to Countenance Sexual Autonomy

As we discussed earlier (see Chapter 2), all of mental disability law is influenced by the pernicious power of the vividness heuristic: A cognitive simplifying device that teaches us that "when decisionmakers are in the thrall of a highly salient event, that event will so dominate their thinking that they will make aggregate decisions that are overdependent on the particular event and that overestimate the representativeness of that event within some larger array of events" (Schauer, 2006, p. 895; see, generally, Perlin, 2003c). This leads to paralyzing fear of negative publicity on the part of institutional administrators if patient sexuality were to ever be sanctioned.

This fear is shortsighted. Failure to take seriously issues of patient sexual autonomy is self-defeating. It ignores the reality that most patients will be reintegrated into a community in which sexuality is an important component, and it stems from our discomfort with even defining "sex." Hand in glove with this fear is the concomitant failure to consider that the opportunity to engage in an intimate relationship may be critical to a patient's adjustment to the outside world once released (see Marshall et al., 1996, p. 220: "Intimacy deficits and loneliness are linked to actual offending").

The opportunity to take part in intimate relationships may be critical to a patient's successful reintegration into the outside world (Perlin, 1993–94, p. 524). "Is it clinically beneficial or antitherapeutic to allow institutionalized patients autonomy in sexual decision making? In answering this question, to what extent ought we consider research on the therapeutic value of touching and physical intimacy?" (id., citing, inter alia, Montagu, 1971). Other questions must be answered as well: "Should the projected length of a patient's hospitalization affect the restrictions placed on their sexual autonomy? If so, how? What is the impact of sexual activity on different methods of treatment? On the overall ward milieu? What correlative responsibilities come with the assertion of rights? Is the potential relationship between sexual repression and neurotic behavior, articulated most vividly by Wilhelm Reich, worth considering?" (id., citing, inter alia, Reich, 1961).

Professor Heather Ellis Cucolo has focused on this in her recent work on sex offenders. She asks why we fail to acknowledge that the concept of intimacy is "the key to preventing and minimizing re-offense" (2007). This is a reality that must be considered as we further explore this issue (see, generally, Doherty, 1971, pp. 283, 287). The literature is clear: We impose significant barriers that prevent institutionalized persons with mental disabilities from establishing intimacy (Cook, 2000). Yet, one study showed that most patients in high-security hospitals "valu[ed] being in a caring relationship [while] in the hospital" and that there was likely "an ongoing desire for intimacy regardless of gender, diagnosis or offense group" (Hales et al., 2006, p. 260).

B. A Tension between an Individual's Right to Free Expression of Sexuality and Concern That a Patient Might Act Coercively toward Another Patient, Especially in a Mixed-Sex Ward

This is, in many ways, the knottiest problem of all, and one that needs serious and sober thought. A forensic hospital, by definition, is a closed ward in most jurisdictions. Inside such a hospital, it may be more difficult to avoid contact with someone who is "sexually interested" than it often is in the "free world." At least one federal appellate court has ruled that "there must be a fundamental constitutional right to be free from forced exposure of one's person to strangers of the opposite sex when not reasonably necessary for some legitimate, overriding reason" (*Kent v. Johnson,* 1987, p. 1226). How may the right of institutionalized patients to be free from unwanted sexual attention be safeguarded in this context? Policy makers need to take this problem seriously in crafting any sort of protocol. When they do so, however, they should consider that a recent study of sexuality in a high-security hospital concluded that there was "little evidence" of patients in that setting being coerced into sexual relationships (Hales et al., 2006, p. 260), while another found no differences in the rates of sexual behaviors between mixed and singe gender wards in acute hospital settings (Bowers et al., 2014).

It is not enough for hospital administrators to presume coercion, using that assumption as a basis for denying patients their right to free expression. They must instead carefully craft policies that protect individuals from "unwanted sexual attention" while still safeguarding autonomy. There is no evidence that this is an issue being taken seriously (see Spector, 2008, newspaper story quoting a patients' rights attorney questioning whether "women in psychiatric hospitals are even capable of consenting to sex").

C. A Failure to Define What We Actually Mean by "Sex"

Without belaboring the obvious, what are we talking about when we say "sex"? We discuss this extensively in Chapter 5, but it is necessary to consider this at this juncture, since our failure to define and discuss sex reflects our social discomfort and squeamishness with this entire matter. One of the coauthors (MLP) has asked, explicitly: "Does it make a difference if we are discussing monogamous heterosexual sex, polygamous heterosexual sex, monogamous homosexual sex, polygamous homosexual sex, or bisexual sex? Does sex mean intercourse? What about oral sex? Anal sex? Masturbation? Voyeurism? Exhibitionism?" (1993–94, p. 527). To put this issue in perspective, as recently as 1973, 50 percent of caregivers at an institution for persons with disabilities would stop patients from "kissing or hugging" (Deisher, 1973, pp. 148–49). Official policy at at least one California forensic hospital spells much of this out (see Sy, 2001, p. 546, Napa State Hospital forbids "open mouth kissing, oral stimulation of genitals [including breasts], anal stimulation or intercourse, sexual intercourse . . . promiscuous behavior . . . prolonged closed mouth kissing, intimate body to body contact, touching underneath clothing, touching of genitals [including breasts], exhibition of the body in any manner judged to be provocative and sexually solicitous"). But this, for better or worse, is exceptionally rare.

Homosexuality also presents a uniquely gendered set of stereotypes about males and females. The general public views male and female homosexual behavior differently, and issues of consent may also be based on gender (Gotell, 2012). Further, it may be possible that a facility would only allow heterosexual encounters based on bias, or homosexual activity between females and not males. These issues of gender-based discrimination of sexual activities must be taken into account when an institution is working to determine how to appropriately allow for consensual sexual encounters between patients.

Interestingly, in one of the few cases establishing any sort of right to sexual interaction, a federal court in Ohio held—gratuitously, apparently, as there is no evidence that this issue was ever raised by either party in court pleadings or oral arguments—that Lima State Hospital patients have a right to be "provided counseling or other treatment for homosexuality" (*Davis v. Watkins*, 1974, p. 1208). Although this language does not appear to have been adopted by other courts (and the decision is over 40 years old), we would not be so bold as to predict that sexual-preference issues would pass entirely under the social radar if sexual autonomy rights were to be granted to forensic patients.

D. The Disconnect between Patients' Rights and Public Views

Notwithstanding the fears and examples of short-sightedness catalogued above, the reality is that institutionalized persons with mental disabilities—including forensic patients—do have at least some right to sexual expression and autonomy (on their rights under the Americans with Disabilities Act, see Chapter 3; see, generally, Perlin, 1999; on their rights under international human rights law, see Chapter 3; see, generally, Perlin and Schriver, 2013). By rejecting this legal reality, public opinion creates a social disconnect and allows for an irrational universe in which the extent to which a patient's rights may be vindicated may well rest on a triviality, such as which institution within the same geographic region of a state in which a patient is housed.

It goes without saying that there is a wide disconnect between potential legal sources that might support the right and public opinion that utterly rejects that position. It is not difficult for us to predict the level of public outrage if this idea were to be suggested by a politician. There was a movement to drum out of office the New York City chancellor of education when he said that condoms should be made available to high school students (see Perlin, 1993–94, p. 526, n. 44). The reaction to what we are discussing here would be, we expect, more intense. But that should not end the discussion. At the least, the idea that institutionalized psychiatric patients have some sexual autonomy rights should be tested in a court of law—an arm of government presumably less susceptible to the vicissitudes of public pressure than administrative agencies.

Consider, in this context, the extent of the intrajurisdictional inconsistencies that often accompany the development of institutional sex policies. In her article about sexual activities in California institutions, Winiviere Sy points out the significant disparity between the restrictive policies at Napa State Hospital (discussed above) and the less restrictive ones at Sonoma Developmental Center, where patients were allowed to engage "in activity directed to sexual arousal, because the expression of one's sexuality is the right of every person" (see Sy, 2001, p. 547; but see, Beh, 1998, p. 119, "Having sexual relations is not a medical necessity," quoting Aetna US Healthcare newsletter, explaining why it declined to cover Viagra as part of its insurance plan). In at least one New York hospital, there have been different policies for male and female patients. Male patients leaving the facility on unsupervised community leave would be given condoms upon request. Female patients, on the other hand, had to have their competency (informally) assessed before birth-control pills could be prescribed (Perlin, 1993–94, p. 541). This makes no conceptual sense, of course, and is most likely a reflection of the head-in-the-sand way we approach the underlying issues. Ironically, much of the development of patients' rights litigation over the past 35 years has gone to ensure that there are "individualized treatment plans" for each institutionalized individual (see Perlin and Cucolo, 2015, § 7-3.1.3). But we totally ignore this when it comes to issues of sexuality.

III. Other Social Policy Issues

A. Personal Issues

1. Masturbation

i. In General. Although sexual activity often refers to intercourse where two people are involved, one such variation of sexual activity is masturbation (see generally, Gill, 2012; Perlin and Lynch, 2014). While not often discussed publicly, society seems to generally accept that people masturbate, and it does not have the same kind of taboos associated with it as other, less mainstream kinds of sexual acts. In fact, masturbation training in sex education "represents one of the few sanctioned approaches for individuals with intellectual disabilities" (Gill, 2012, p. 472; but see id., p. 482: "Masturbation remains a controversial practice for sexual promotion for moral reasons and social taboos").

It should be noted at the outset that "the meaning behind masturbation fluctuates based on historical situations" (id., p. 477). Although currently, it is generally (though not in certain orthodox/fundamental religious communities) seen as a (mostly) solitary and enjoyable practice, this has not always been the case. Historian Julie Peakman reminds us that "in the past, such practices were considered a perversion against nature, a heinous sin and a habit that brought about serious physical and mental disabilities" (2013, p. 45; on the roots of the nineteenth century view that masturbation was a cause of mental disorder, see Hare, 1962). As recently as the 1970s, staff at facilities for persons with intellectual disabilities squirted lemon juice into a resident's mouth if he masturbated "excessively" (Gill, 2012, p. 474, quoting Cook et al., 1978, p. 132); this was seen as a more "humane" intervention that what had frequently been used previously—electroshock therapy (id.). Even one of the most enlightened books on sexual understanding from that decade discussed the purported connection between "excessive" masturbation and the "schizoid person" (Offit, 1977, p. 94).

Masturbation was a capital offense in South Africa until recently (Brown, 2010, p. 457) and was regularly classified as a "sin against nature"—along with coitus interruptus, contraception, sodomy—because of its nonprocreative nature (Wilson, 2003, p. 226, n. 285), a classification that dates at least to the writings of Thomas Aquinas in the thirteenth century (Wishard, 1989). Remarkably, *prostitution* was seen as a "necessary evil" to combat masturbation (Carrasquillo, 2014, p. 701). Generally, though, attitudes toward masturbation have undergone a "radical change" in the past centuries, and it is now generally seen as "a healthy and necessary alternative to vaginal penetrative sex" (Peakman, 2013, p. 72–73). Valid and reliable research concludes that it is a means of achieving sexual health (Coleman,

2003) and that it is an "acceptable and natural part of an individual's sexual behavior" (Mental Welfare Commission of Scotland, 2012, p. 20).

If masturbation is viewed as an appropriate practice, institutions must be prepared to create safe spaces for patients, just as a noninstitutionalized person would be able to find his or her own space to privately engage in masturbation. If one is in a facility that denies privacy, where can one masturbate in a "safe place"? (Gill, 2012, p. 472). Although sexual behaviors of all sorts are seen generally as private matters, it becomes a public issue within the context of institutionalization (id., p. 480, citing McGaughey and Tewksbury, 2002, p. 135). All of this, though, is always shrouded in secrecy. As Professor Gill notes, "The masturbatory closet remains shut" (Gill, 2012, p. 477).

Beyond allowing masturbation for patients who are institutionalized, there is also a benefit to engaging in masturbation training, particularly with individuals who may need sexual health education. Siebers has listed four benefits of masturbation training:

1. To help patients with mental disabilities understand that sexual acts should be private, allowing authorities to eliminate offensive behavior from public spaces;
2. To provide patients with a means of releasing tension and controlling frustration, creating a more passive and manageable population for caregivers;
3. To teach safer methods of masturbation to patients who are injuring themselves in the pursuit of sexual pleasure; and
4. To introduce the pleasures of sexuality as part of typical human existence to people for whom these pleasures are unknown. (1998, p. 162)

Siebers recognizes the therapeutic value of this practice, which is an important consideration. Not only does this training teach appropriate behaviors, but it also allows for therapeutic "release" of urges or frustrations in a safe way, something that otherwise may never be discussed with these patients.

ii. Gender Issues. Of course, there are gender politics to consider here as well (see Perlin and Lynch, 2014). Masturbation, is generally viewed as an activity that men engage in more frequently than women, with the thought process of many being that men somehow "need" to engage in masturbation, while women choose to without the same need (but see Peakman, 2013, p. 72, discussing British survey indicating that 71 percent of women between 16 and 44 masturbated, quoting Gerressu et al., 2008; see also, Bretschneider and McCoy, 1988, indicating that 40 percent of women over the age of *80* masturbated). Interestingly, in contemporary sex therapy, it has been hypothesized that teaching women how to masturbate to orgasm could be an effective way to counter hypoactive sexual desire disorder, which indicates low desire for engaging in sexual activities (Zamboni and Crawford, 2002). Tellingly, virtually all of the relevant academic literature focuses solely on issues of *males* masturbating as "the sexuality and sexual experiences of women with . . . disabilities have remained relatively hidden" (Cambridge et al., 2003, p. 253; see also, e.g., Bell and Cameron, 2003, p. 128, discussing a woman with limited verbal communication who "appeared to have no recognition of female masturbation"; see Perlin and Lynch, 2014).

A person's sexuality is often entwined with his or her gender identity. This can result in different treatment based on that identity. Issues of men's and women's sexuality are viewed differently by society, especially with regard to the sexual needs of both genders. This conflicts radically with the position of respected scholars who argue that sexual release *for all persons* is as much a basic need as the need for sleep or food (e.g., Bahner, 2012; Mona, 2003). With the addition of a mental disability, these issues become even more difficult to contend with (on gender differences in sexuality in general in this context, see Petersen and Hyde, 2010).

The types of sexual activities discussed here demonstrate some of the gender disparities of our society that have also become obvious in issues of sexual activity. As just discussed, masturbation is generally viewed as an activity that men engage in more frequently than women, with the thought process of many being that men somehow "need" to engage in masturbation, while women choose to without the same need. Ironically, in contemporary sex therapy, it has been hypothesized that teaching women how to masturbate to orgasm could be an effective way to counter hypoactive sexual desire disorder, which indicates low desire for engaging in sexual activities (Zamboni and Crawford, 2002, pp. 138–39).

B. Institutional Issues

It is essential that we focus specifically on the attitudes of institutional administrators (see Perlin and Lynch, 2015b). As recently as 1973, 12 percent of caregivers at an institution studied said that they would punish residents for masturbating (Deisher, 1973, p.148. More recently, at least one study has found that staff workers at a medium-security facility for persons with intellectual disabilities generally held "liberal attitudes" toward masturbation (Yool et al., 2003; on the needs of staff in dealing with sexuality issues, see McConkey and Ryan, 2001), and another article has called for "masturbation training" (Gill, 2012; see also, Kaeser, 1996); yet, much controversy swirls around the question of *facilitated* masturbation and the role of the caregiver in the facilitation process (Earle, 2001). It goes without saying that this is an issue that must be subject to discussion in an "open and value-free environment" (Glass and Soni, 1999).

Tellingly, at least one academic consideration of the issue has noted that concern within provider services often returns to the question of "whether such interventions, if successful, will then lead to the person spending too much time masturbating, as they may have learnt how to do it well and effectively" (Cambridge et al., 2003, p. 260). This is consistent with the observation that "sexual expression is not a problem for people with cognitive disabilities—but for those who work with them" (Tarnai, 2006, p. 151). Patients in facilities for persons with developmental disabilities are frequently discouraged from masturbating based more often on moral judgments and prejudices than on valid clinical considerations (Shelton, 1992). And an entirely different set of issues is raised when masturbation in jails and prisons is considered, as most such policies ban it entirely (Cusack, 2014b).

C. Procreative and Reproductive Issues

As discussed elsewhere in this work, Professor Maya Sabatello has argued persuasively that Articles 2, 23, and 26 of the United Nations' Convention on the Rights of Persons with Disabilities provides a "possible venue to further advance a right to found a family through 'assisted reproductive technologies'" (2010, p. 259). She continues by noting that, from the goal of ensuring equality of rights, nondiscrimination, and inclusion to its requirement to eliminate historical prejudice through the concept of "reasonable accommodation" to its explicit references to family rights, and to the link the treaty makes between all these and scientific developments as a means to achieve these goals, the Convention is "ripe to provide an appropriate remedy" (id.).

Professor Sabatello's insights come at a propitious time, as other scholars are now beginning to explore the notion of "reproductive justice" in support of arguments that the fundamental right to procreate as protected by the US Constitution includes a fundamental right to use assisted reproduction (Mutcherson, 2015). Professor Kimberly Mutcherson's article—identifying procreation as biology and social construction, and *not* "just sex, just pregnancy [nor] just parenting," (id., p. 22)—reminds us that the history of "sterilization abuse of persons with disabilities" is part of our history of "procreation as a site of subjugation" (id., p. 75). She is clear that, under the regulatory scheme that she proposes (a two-tiered level of constitutional review of the "fundamental right to non-coital procreation" (id., p. 22), "sex has inherent value and warrants respect for reasons independent of its procreative potential" (id., p. 36).

In this context, a recent article by Rima Kundnani discusses the impact of the eugenics movement on the forced sterilization of women with mental disabilities (the motivations of which, she argues, still persist, noting that involuntary sterilization justifications for mentally ill women are now "couched in terms designed to make sterilization seem more palatable, ostensibly protecting the personal rights of the women involved" (2013, p. 68, quoting Horsburg, 1996, pp. 569–70), and concludes that a hybrid approach—combining aspects of the "best interest" standard and the "substituted judgment" standard (id., pp. 83–84), concluding that "if clear and convincing evidence exists to show that the incompetent woman would have made a particular decision if competent, that decision should be adhered to regardless of what a judge would deem to be in her best interest" (id., p. 84). Such a standard, she believes, "guarantees better results than any of the current standards alone because it ensures maximum autonomous decision making for mentally incompetent women while limiting judicial discretion" (id., p. 89).

We are somewhat less sanguine than Kundnani about the likelihood that judges will actually follow this proposed standard, for the reasons that we discussed extensively in our chapter on sanism, pretextuality, heuristics, and "ordinary common sense." Weighing choices in judicial language, Amy Hodges has noted in this context—quite accurately, to our minds—that views of "society and preconceived notions infiltrate judicial opinions"; whether specific words were used consciously or not, the words "show a need for concern for the equality of groups in minority status before the law" (Hodges, 2005, p. 439). But Kundnani's crafting of a standard is welcome as it will, we hope, call attention to a topic that is gravely underconsidered by scholars and by policy makers.[1]

1. Abortion

What about abortion rights (see Perlin, 1993–94, p. 542)? In what way do institutionalized women's abortion rights differ from those possessed by women in the free world? A Rhode Island case, by way of example, has held that a trial court's authorization of the performance of an abortion on a mentally retarded woman was reasonable, based on a finding that the woman would have exercised her right to terminate her pregnancy had she been competent to make such a decision (*Doe,* 1987, p. 526). The trial court based its conclusion on the pain and disability caused by pregnancy would have had a "special impact upon this individual in light of her underlying conditions of seizure disorder and cerebral palsy" (id.; compare Capability

Scotland, 2015: "Generally, there is no medical reason why a woman with CP should not have a baby, with no greater risk of miscarriage or premature birth").

What about their right to resist an abortion? There is at least one reported example of a suit for damages in response to an unauthorized abortion that was performed on an institutionalized woman with mental disabilities (*McCandless v. State,* 1956). Anecdotal evidence suggests that it is not rare for state hospital doctors at certain facilities to attempt to coerce patients into terminating pregnancies (Perlin, 1993–94, p. 542, citing a telephone call with Gould, 1992). If there is subsequent litigation on this question, how will courts respond? (Compare *Doe v. General Hosp., 1970,* challenging hospital regulations that permitted abortions only when necessary to protect pregnant woman's mental health as evidenced by a provable history of mental illness, with *People v. Barksdale,* 1972, upholding state's abortion law allowing abortions only where a woman's continued pregnancy would create a substantial risk of her experiencing gravely impaired physical or mental health, both cases decided pre–*Roe v. Wade.*)

D. Issues That Implicate Others' Rights

1. Medication Side Effects

For individuals with mental and physical disabilities, the medications prescribed to them have had both positive and negative effects for a number of reasons. One of the drawbacks most frequently discussed by individuals and caretakers are the sometimes-severe side effects that medications—particularly antipsychotic medications—can have on an individual's quality of life (see Perlin and Cucolo, 2015, § 8-2). However, while side effects of medications are generally discussed, often with concern and compassion, specific side effects that relate directly to sexuality—be it sex drive, performance, or ability—are frequently overlooked or underdiscussed.

Prescription medications are among the most common causes of sexual dysfunction; in fact, studies show that one out of every four reported cases of sexual dysfunction can be blamed on a prescription drug (Crenshaw and Goldberg, 1996). Some medications that can impact sexual activity, like statins and blood pressure medications, are fairly innocuous and commonly prescribed to people with and without an attached stigma of "disability," so it is more likely that people taking them will speak to their doctor about the problems they experience sexually. Other medications like antidepressants, antipsychotics, and benzodiazepines may be more likely prescribed to individuals who will have the stigma of being "an individual with a mental illness," making the equally problematic effects of these medications more difficult to discuss or more readily ignored by sanist doctors who paternalistically decide that giving up one's desire to engage in sexual activity is a fair trade-off for mental health stability. (Cutler, 2003)

Failure to ejaculate, impotence, and decreased libido are among the top complaints of individuals taking medication for a mental health condition (Smith et al., 2003). The medications used to treat everything from anxiety to depression to schizophrenia all act on various neurotransmitters and chemical pathways in the brain (Baldwin, 2003). For example, antidepressants affect three major neurotransmitters—acetylcholine, serotonin, and norepinephrine. These particular neurotransmitters may be particularly integral to sexual performance and libido, so a medication that affects the ways in which signals are transmitted and understood by the brain can have detrimental effects on sexual ability and desire (id.).

Equally problematic, but far less understood, are the problems caused by antipsychotic medications (Smith et al., 2002). Lack of properly documented patient complaints and significant paternalistic, sanist bias are both largely responsible for how little we understand about the sexual side effects of these medications in particular. As discussed above, talking to one's treating physician about a heart medication that decreases libido is generally a more common, comfortable conversation for an individual than talking to a psychiatrist in a mental health unit about a desire to change or lessen medication for schizophrenia because of the same sexual side effects.

One study in 2003 acknowledged that "few studies have addressed the effects that iatrogenic sexual side effects have" on medication compliance and willingness to continue with drug treatment in the population of individuals with severe mental illness (Rosenberg et al., 2003). Researchers found that, within a sample of 51 individuals, 62.5 percent of males and 38.5 percent of females felt that their psychiatric medications were causing sexual side effects. Most significantly, even given these percentages, 50 percent of the individuals sampled "never or infrequently" discussed these concerns with their mental health care providers. This number is even more significant when broken down by gender, with 80 percent of women who believed that psychiatric medication was impacting sexual function never discussing it with treatment providers (id.).

This study is significant in that it demonstrates the high percentage of sexual issues reported with psychiatric medications. However, it only sampled outpatients who had a preexisting relationship with a mental health treatment professional. It is reasonable to assume that the percentage of individuals who would not feel comfortable addressing these issues would increase in a mental health facility.

Additionally, this study implicates the gender dynamics that we discuss frequently in this book. Women clearly felt less able to talk to their health care providers about the sexual side effects these medications caused—they experienced these side effects, yet the percentage who chose to communicate this to their treatment providers was significantly lower than with men. We can guess that this may be due to the gendered stereotype that for men, sexual function is pivotal and is allowed to be a concern large enough to change medication or treatment, whereas for women, sexual function may be seen as negotiable or not as critical as it is to men. Women may believe that side effects relating to sexual function are an acceptable cost of taking otherwise helpful medications and may choose to live with those side effects, whereas men who have been conditioned to believe that their sexual function is a right may be more vocal about side effects they experience.

Rosenberg et al. (2003) also found that 41.7 percent of men and 15.4 percent of women had stopped taking medications at some point due to the effects they were having on sexual function. Again, there may also be some gender dynamics at play here, where more men felt justified in stopping the medication based on sexual dysfunction. Ultimately, this study, and others like it, only scratches the surface of how individuals with mental illness relate to sexual dysfunction caused by psychiatric medication. It also highlights problematic gender stereotypes about sexuality that we discuss in greater detail in Chapter 5. Those stereotypes are clearly present in the individuals affected, as well as society at large, given the disparity between men and women who are vocal in addressing problematic sexual side effects of medication.

Even in the law, medication side effects generally are weighed against the good that these drugs can do for individuals with mental illness. In New York, individuals who are involuntarily committed can choose to refuse medication for any number of reasons, including side effects that impact their ability to engage in sexual activity; however, they can be brought to court by a psychiatrist seeking to prove that medication is necessary. This process was created after the 1986 state court decision in *Rivers v. Katz*, which dramatically changed the state procedure for responding to those patients who formally refused psychopharmacologic treatment (Ciccone et al., 1990). The court in *Rivers* rejected the medically administered review process that had been used to respond to patients who refused medication, and replaced it with a judicial determination of competent and "substituted judgment" provided by the court (*Rivers v. Katz*, 1986). While *Rivers* takes the decision about forced medication out of the hands of psychiatrists directly, it still allows for significant judicial interference based on input from psychiatrists (McKinnon et al., 1989). In practice, this could make very little difference to individuals with disabilities who are refusing medication based on side effects hindering sexual performance. The court's standard of substituted judgment does not guarantee that a judge will consider an individual's sexual function to be a deciding factor in whether or not to approve an order of forced medication.

Treatment professionals generally have yet to identify sexual dysfunction as a significant enough problem to warrant better data when looking at effectiveness and satisfaction with medications generally used to treat individuals with mental disabilities. They continue to focus on the issue of how these side effects impact medication compliance generally, rather than acknowledging that sexual dysfunction is, by itself, its own issue. The law has not done a better job, only taking a sanist, paternalistic approach to forced medications for individuals with mental illness without regard to side effects beyond the ones that are deemed appropriate to discuss.

2. Sex Education Issues

The valid and reliable research is clear: Studies have shown that sex education counseling is effective when given to residents in psychiatric institutions and individuals with intellectual disabilities (Sy, 2001, p. 571, citing McSherry and Somerville, 1998). It has been shown to be beneficial in that "sex education for the chronic patient will help resolve the conflict . . . between patients' comfort with their actions and their discomfort with their sexual thoughts and feelings. This conflict resolution may help to make sexuality a more positive part of their lives" (Sy, 2001, p. 571, quoting McSherry and Somerville, 1998, p. 128). As adults with intellectual disabilities are frequently less knowledgeable about almost all aspects of sex, it is especially important that individuals in residential services have ongoing access to sex education (Murphy and O'Callaghan, 2004). Such education is critical for staff, as well as for patients (Dobal and Torkelson, 2004).

The main problem here is parents. There is not widespread sex education for persons with intellectual disabilities, in large part due to parental objections to sexual education for their intellectually disabled children (Reed, 1997; McCabe, 1993).[2] Many parents oppose sex education because they feel their children are not capable of understanding the information, or they feel it would be "bad for them," by giving them "wrong ideas" and "overstimulat[ing] them" (Fegan, Rauch, and McCarthy, 1993, p. 11). Many parents of this population also have succumbed to what is called the "forever child syndrome," as a result of which children are regarded as "eternally innocent" and asexual (Reed, 1997, p. 804, quoting Kempton and Kahn, 1991, p. 97). As a result, basic right to information and education is often not given to individuals with significant disabilities in regard to sexuality (Wade, 2002).

Another problem that may arise is the quality of the program. In an analysis of sex education programs in place in the Netherlands, Dilana Schaafsma and colleagues concluded that the programs were unlikely to be effective, finding it "remarkable" that a host of issues—the fact that people with intellectual disabilities have had fewer sexual experiences than others, that they often have negative attitudes toward sexual activities, and often have had experiences of sexual abuse—were not considered in the creation of the programs (2013). Certainly, these are the sorts of issues that must be taken seriously by program developers.

3. Sex Surrogacy

i. Care Workers. Perhaps the most controversial question—in a *sea* of controversial questions—is the appropriateness of using care workers as sexual surrogates in cases involving persons with disabilities (see Perlin and Lynch, 2015b). It is not a surprise that persons with disabilities often have a difficult, or *impossible,* time finding partners. A *New York Times* story told of Laetitia Rebord, a person with paraplegia who uses a wheelchair, who told the reporter, "A disabled person is seen as a child." As she was unsuccessful in finding sexual relationships on her own, or through friends, or on dating sites, she plans to go to "pay for sex in Switzerland or Germany, where so called sexual surrogates are legal" (de la Baume, 2013).

Such surrogacy can involve masturbation or intercourse (see *Touching Base*, http://www.touchingbase.org). Several European nations—including The Netherlands, Germany, Denmark, and Switzerland—allow "limited 'touching' services for [persons with severe disabilities] through non-profit organizations" (Appel, 2010, p. 153). Elsewhere, there are organizations in Canada (http://easecanada.org), Australia (*Touching Base*; http://www.scarletroad.com.au), Japan (http://www.whitehands.jp/e.html [*White Hands*]), and New Zealand (https://www.facebook.com/pages/Paths-Together/552620361438711), that, in the words of the Australia-based *Touching Base* website, "developed out of the need to assist people with disability and sex workers to connect with each other, focusing on access, discrimination, human rights and legal issues and the attitudinal barriers that these two marginalised communities can face" (*Touching Base*). Related, an administrative decision in Denmark has approved the payment of social welfare funding for an "escort girl" as a "handicap benefit" (email from Professor Kirsten Ketscher, Dec. 30, 2013). This should not be a surprise in that, in Denmark, it is the care worker's *duty* to facilitate service users' sexuality, whether it concerns assistance in order to have sex with a partner, to masturbate, or to contact a prostitute (Bahner, 2012, p. 339; on how the right of disabled persons to personal assistance in general is empowering, see Christensen et al., 2014).

Of course, sexual surrogacy is another instance where gender stereotypes play out. The basic stereotype that men somehow need sex, or need to orgasm, whereas women may enjoy it but have no analogous physiological need is apparent in current surrogate situations. Japan's White Hands, for example, provides a service that allows only men to be masturbated. When asked about the viability of a similar service for women, the staff claims they "haven't received any requests from them" (*White Hands*, as quoted in Perlin and Lynch, 2014, p. 269; on how the dilemma of disabled masculinity is almost exclusively focused on men with *physical*, not *cognitive*, impairments, see Shuttleworth et al., 2012).

To what extent might traditional health care providers become involved? A British professor has concluded that, within the concept of "holistic nursing," nurses have an important role to play in ensuring that the sexual needs of their disabled patients are met, perhaps including procuring sex workers, perhaps "masturbate[ing] them when no other form of sexual relief is available" (Earle, 2001, p. 437, quoting Earle, 1999, p. 312). Professor Sarah Earle readily concedes that this topic presents a "complex array of ethical, legal, personal and professional dilemmas," but concludes that "the issue of sexuality should be given greater prominence" in the provision of nursing care (Earle, 2001, p. 438).

Additionally, the gendered availability of this service may also demonstrate another difference rooted in basic anatomy. In order to sexually service a male client, a sex surrogate does not need to perform any act of penetration to allow that client to reach orgasm, whereas for a female, the possibility of penetration may be greater, although it is just as feasible for a woman to reach orgasm without penetration. Even the seemingly progressive White Hands organization may unconsciously be reacting to the differences in services needing to be provided for males versus females. The questions raised on their website ask first, "what exactly do we do [for women], and to what end?" and "would this even be considered a care service?" (id., pp. 269–70). This may be a cultural difference, but it demonstrates the gender split between this service for males being looked at solely as a "care service" while the same needs for women, and whether it constitutes a care service, are debatable. Professor Julia Bahner, by way of example, has discussed some of the ambivalences faced by persons with physical disabilities with regard to the role of their caregiver:

> When discussing sexual facilitation, none of the participants in this study wished their assistants to assist more than to the most basic degree, e.g., undressing, putting in position, putting on a porn movie, putting on condoms or assisting with other aids. Hence, participants drew the line between receiving assistance in order to be able to be sexual on your own or with partner(s) and receiving assistance in the actual sexual activity, which was thought of as crossing the line. (2012, p. 349)

It has been suggested by one medical ethicist that "jurisdictions that prohibit prostitution should carve out narrow exceptions for individuals whose physical or mental disabilities make sexual relationships with noncompensated adults either impossible or highly unlikely" (Appel, 2010, p. 153, but see Di Nucci, 2011, criticizing Appel's position). Although there is at least one report of this having been done using social security funds in the United States (Lillesand and Nguyen, 2004, p. 3, recounting a case where a "sympathetic sister/trustee purchased 'entertainment services,' consisting of nursing home visits by 'escort services' personnel to the nursing home where her severely disabled and dying brother resided"), it is clearly an idea that has not gained significant traction in that jurisdiction. In fact, any such use of sexual surrogacy has been sharply criticized as "distort[ing] sympathies for the situations of people with disabilities to promote prostitution" (Coalition against Trafficking in Australia, undated).

This question, out of all those that arise when looking at sexual autonomy for persons with disabilities, is compounded by societal views about prostitution, exacerbated by the often-sanist thinking about the sexual needs of persons with disabilities (see Perlin, 1993–94; Perlin, 2008b). It is not surprising to see that nations that have legalized the profession of sex worker are more likely to have opportunities for sexual surrogacy (Charts-Bin Statistics Collector Team, 2010). These nations are allowing some of the stigma surrounding sex (and, in particular, sex for people with disabilities) to be lifted, leading to a more honest discussion about meeting the basic needs of people, including the need for sex.

Sexual surrogacy also challenges society to imagine that a nondisabled person would be willing to engage in sexual activity with a disabled person. Entrenched sanism and long-standing fear of "contamination" or disability as a "contagion" also make this concept a difficult one to grasp for many who may be confronted with this form of sexuality (see, e.g., Neaman, 1975, pp. 31, 144).

Although surrogacy is not identical to engaging in an emotional relationship in which sex is a component, it is yet another option for people with disabilities to gain some autonomy in their decision making about their own needs. Under the Convention on the Rights of Persons with Disabilities (CRPD), such persons have the same right to engage in sex that nondisabled people do (CRPD, Art. 23), and surrogacy may afford an opportunity to those people who are, for many reasons, unable to or uninterested in engaging in a nonsurrogate sexual relationship (see Coffey, 2012).

The differences between nations' views on the "acceptability" of masturbation and sexual surrogacy are also indicative of those nations' dominant norms and values. Professor Elaine Craig has discussed the danger of regulating activity based on the dominant norms of a society, stating that if legal standards are applied based only on dominant belief systems, they "[privilege] dominant social, cultural and religious practices" (Craig, 2014, p. 117). Further, in the context of consent laws, she notes that "social approval is not an equitable basis upon which to criminalize particular sexual activities" (id.). Although the disability rights movement has made great strides, persons with disabilities continue to remain a minority group, rather than a part of the dominant culture in most nations.[3] Their rights and needs may not be legislated away by that dominant culture because majority populations believe sexual activities of persons with disabilities do not produce "socially desirable cultural products" (Craig, 2014, p. 117).

E. Issues That Implicate Other Areas of the Law

1. Administrative Law

A unique consideration for individuals with disabilities who live in a facility, rather than in the community, is that there will likely be a more regulated set of rules surrounding the expression of sexuality and engaging in sexual activity. Hospitals, group homes, and developmental centers will likely have policies in place regarding sexual activity that are meant to reduce liability and protect vulnerable individuals. However, not all facilities have incorporated policies that specifically regulate sex (see Perlin, 1993–94, p. 532: "Many hospitals remain reluctant to promulgate such policies"). In those instances, informal rules about sex may be based on staff culture, but there are no explicit regulations in place. (See Chapter 3.)

Current and past hospital policies on sexual interaction necessarily draw from societal attitudes about sexuality, privacy, and the rights of persons with mental illness to engage in these behaviors. As discussed in Chapter 3, there is also often a heavy religious overtone to policies about sexual activity. This can be seen in religiously affiliated hospitals or can be due to a particularly high ratio of hospital staff who practice a particular religion and promote their religion's beliefs about sexual activity (Mossman et al., 1997).

Here is a story recounted to us by patients' rights attorney Debbie Dorfman, describing a client with a mental illness, placed in a nursing home by her guardian, who wanted to have sex with her boyfriend:

> Neither her guardian nor her doctor had any concerns about her capacity to have a consensual sexual relationship. The nursing home administrators, however, refused to allow her to have sex with her boyfriend because she was not married to him and therefore took the position that if she had sex with him, she would be committing a crime.
>
> I had to meet with my client, the nursing home administrators and their attorney. I was told that when I arrived, I should ask for Mrs. X,

> the wife of the nursing home administrator, to check in for the meeting. Accordingly, upon arrival, I did just that. But, when I asked for Mrs. X, the receptionist asked me which one (i.e., which Mrs. X). I responded saying, "What do you mean 'which one'? I mean the wife of the administrator." To which the receptionist responded by saying again "which one" and then led me into a large conference room filled with over ten women of various ages and one small man. I was introduced and then they introduced themselves all as Mrs. X and the man as Mr. X. It turned out that they were all the wives of Mr. X and the Mrs. X that I was to ask for was the "head wife." Upon learning of the multiple wives, I quickly pointed out to their attorney, in front of them, that they were hardly in a position to say that my client was going to be committing a crime by having sex with a man to whom she was not married given that the administrator and all of the wives were committing the crime of polygamy—which I emphasized to their attorney IS a crime in Utah and the US and also violates the Utah Constitution. After pointing out these facts, they quickly relented and agreed that my client could have sex with her boyfriend and in fact, that he was welcome to come to the nursing home and that they would provide privacy for them.

Attitudes about policies regarding sexual activity are invariably linked to the particular dominant culture at a facility, so surveys about what is and is not acceptable truly run the gamut. However, generally, masturbation is viewed to be harmless and reasonable if done "privately and appropriately," but sexual interaction between patients is to be "discouraged" (id.). However, in some of the more liberal hospitals, policies exist that promote, rather than discourage, sexual behavior and provide privacy and education for patients looking to engage in sexual activity (id.).

One of the coauthors (MLP) and two colleagues—a forensic psychiatrist and an attorney who represents institutionalized persons with disabilities—created a Model Policy Concerning Sexual Relations among Long-Term Psychiatric Inpatients that incorporates both hospital administration concerns about liability and the necessity of maintaining patient autonomy. It begins by outlining the authors' beliefs about the importance of allowing for consensual sexual activity, stating:

> Human beings have an innate need and desire for emotional and sexual intimacy. This model policy offers psychiatric facilities guidelines to balance the rights and needs of patients with health and safety concerns . . . Competent patients who reside in intermediate- and long-term care facilities should not be prevented from engaging in consensual sexual relations . . . All mental health facilities should offer patients sex education and contraceptive counseling services, and should make contraceptive devices reasonably accessible to their patients. (Mossman et al., 1997)

The policy covers issues such as assessing competency during screening, learning about an individual's sexual history and exposure to STDs, and providing information about practicing safe sex. There are also specific categories for assessing competency and the provision of counseling and contraceptives to patients. The authors also explicitly include a section on the importance of maintaining privacy and dignity, concepts that are often lost in the rush to create lawsuit-proof policies about consensual sexual activity. Specifically, the policy requires that staff not bring their own biases into patients' decisions to engage in consensual sex, stating that staff members will:

1. Provide a dignified setting for patients to engage in sexual relations.
2. Treat all patients expressing a desire for sexual interaction with respect and dignity.
3. Discuss any issues regarding the patient's decision to have sex and any questions openly and frankly.
4. Not act in a manner causing the patient to feel ashamed, embarrassed, or intimidated for wanting to have sex or for having questions or concerns (id., p. 456–57).

The policy also contains specific guidelines for staff training, both in how to safely facilitate consensual sexual activity and in how to respond to allegations of abuse or assault.

Hospital policies that fail to acknowledge the reality of life on the units are out of touch at best and detrimental at worst (Wasow, 1980). Pretending that patients do not want to engage in sexual activity, or that it does not already happen even with prohibitions against it, is not good policy making. Refusal to recognize the potentially important role that autonomy, and making the choice to engage in consensual sex, can have for patients is short-sighted (Keitner and Grof, 1981). Failure to provide realistic policies then leaves staff working on the units with no guidance and allows them the freedom to impose their own beliefs on individual patients. Failure to adequately craft policies can also lead to difficulties in managing risks related to sex, including assault or abuse.

2. Tort Law

The fear of tort litigation concomitantly ignores potential tort exposure for maintaining the status quo ante. Fear of tort-based litigation has led to overconfinement and overuse of restraints (see Perlin, 2000b; Perlin and Cucolo, 2015, § 8-9.6), notwithstanding a robust collection of cases that have found liability in cases involving improper commitment (id., § 12-1.7.4) or improper use of restraints (id. § 12-1.7.5.6). In response to the frequently expressed fear of litigation, one of the coauthors (MLP) posed the question this way in an earlier article:

> How will the well-documented fear of many mental health professionals of being sued—what some commentators term "litigaphobia" [see Brodsky, 1988, p. 497, discussed in a tort law context in Perlin, 1992c, pp. 61–62]—affect the adoption of, or compliance with, any policy that appears to increase the potential for patients' sexual activity (for fear that litigation might quickly follow unwanted births or the spread of sexually transmitted diseases)? (Perlin, 1993–94, pp. 525–26)

This fear ignores the possibility that patients might sue for violations of their state statutory rights, federal Americans with Disabilities Act (ADA) rights, or international human rights, triggered by a deprivation of sexual autonomy (see, e.g., *Foy v. Greenblott*, 1983, discussed extensively in Chapter 3). This is a possibility never discussed in this policy debate.

For those both in and out of facilities, an overarching paternalistic set of concerns about caretaker liability and safety of vulnerable populations have been controlling factors in establishing rules for individuals with disabilities to engage in sexual activity. When hospital administrators and treating psychiatrists are asked whether patients should be able to engage in sexual activity on the units, they frequently cite potential liability risks like physical and emotional injuries, unanticipated pregnancy, and the spread of sexually transmitted diseases (STDs) (Mossman et al., 1997; Commons et al., 1992). However, these liability concerns do not stop patients from engaging in sexual activities. Further, there are several questions raised by the actions of doctors who fear liability and regulate away patient autonomy; most important, whether a hospital's fear of liability gives a hospital administration the unlimited right to deter patients from sexual activity (Mossman et al., 1997).

There are a wide range of liability concerns that a hospital may face in a civil tort claim based on patient sexual encounters; however, case law remains fairly limited and ambiguous, allowing administrators to justify seemingly unnecessary or paternalistic policies that may or may not shield them from liability. Cases that have been brought where an individual or a hospital has been found liable, however, generally are based on an incident of sexual assault or rape, rather than a consensual sexual encounter. *Foy v. Greenblatt* (1983), discussed below, is the only case that indirectly deals with consensual sex. However, in *Foy*, the issue was the birth of a child resulting from the consensual sex, rather than the sex itself.

The spread of sexually transmitted diseases has long been a concern, and, especially after the introduction of HIV/AIDS, hospitals increased their awareness of sexual activity that could lead to its spread (Zonana et al., 1988). Hospital administrators feared that an instance of HIV transmission from one patient to another could be grounds for a lawsuit claiming negligent supervision (Mossman et al., 1997).

A particular concern unique to tort law is that of "wrongful birth." In these cases, a mother brings a claim against a medical professional or hospital stating that she gave birth, despite a desire not to do so, and that her condition was not effectively managed by the medical professional. Consider *Foy v. Greenblott,* a 1983 California case in which Virgie Foy alleged that her son's "wrongful birth" resulted from negligence in controlling her behavior in the mental health facility where she engaged in consensual sex with the boy's father. Foy sued the facility, her guardian, and her physician. As discussed in Chapter 3, the appeals court in California found that a hospital does not need to prevent a patient from engaging in sexual activity based solely on that patient's incompetence. The court held that failure to prevent the voluntary sexual encounter that led to the birth of her son did not provide grounds for Foy to bring a suit (*Foy,* 1983, p. 91).

The *Foy* court not only established that consensual sex between patients was not something that needed to be banned for fear of liability, but also laid the groundwork for incorporating the use of education, counseling, and contraceptives for patients looking to engage in sexual activity. The court said that failure to make these options available to Foy could have been grounds for a claim, if Foy could show that she would have made use of options like contraceptives or counseling from staff. However, the court went even further in protecting patients' rights, saying that case law and statutes have established a policy preference for maximizing reproductive choice, and allowing for patient autonomy, and finding that the "threat of tort liability for insufficient vigilance in policing patients' sexual conduct . . . would effectively reverse these incentives and encourage mental hospitals to accord mental patients only their minimum legal rights" (id., p. 91).

While the wrongful birth cause of action is not widely recognized, hospital administrators likely continue to face pressure to ensure that they cannot be held liable for unwanted pregnancies or the spread of STDs that they fear may become problematic if patients are allowed to have sex. Additionally, beyond civil tort claims, administrators may be concerned about criminal liability. For example, in Ohio, a person who has intercourse knowing that "the other person's ability to appraise the nature of or control his or her own conduct is substantially impaired" can be arrested and tried on a felony charge. Hospital staff who allow this kind of activity could then be indicted for facilitation of a crime (Mossman et al., 1997; compare with Kaplan, 2015, a husband, indicted for having sex with wife who had dementia, acquitted after jury trial).

Ultimately, hospital administrators need to recognize the differences between consensual sexual behavior and unwanted sexual conduct, and understand that while protection against the latter is important, preserving patient autonomy is an equally relevant concern. Liability will not automatically increase if patients are provided with options like contraceptives and sex education.

Conclusion

In short, there are multiple other issues that must be taken seriously by all who are involved with or concerned about this area of law and social policy. It is essential that the topics discussed in this chapter be considered carefully, especially in light of the fears that are so often expressed both by facility administrators, the media, and the general public. Once more, we cannot escape the sanist motivations for so many policies (either formal or informal) now in place.

5

Gender, Society, and Sexuality

I. Historical and Contemporary Attitudes toward Sexuality and the Role of Gender Identity

This book is unique for multiple reasons. The overlap between sexuality and disability is not a common topic for scholarly articles, and even less common in the context of legal impediments to the free exercise of sexual autonomy. While we are writing to try to shed some light on this neglected field, we also believe that the issues inherent in a discussion about sexuality must be understood in their broader context. This requires knowledge of gender, sex, social constructs, and the fluidity of these concepts, as well as enough historical information to adequately contextualize a modern discussion of these issues. A sociologically focused discussion of the history of sexuality, the gender dynamics always at play in issues of sex and sexuality, and the ways in which stereotypes and biases intersect and overlap within various populations must take place in order to more fully understand all the dimensions of this topic.

There is a robust literature that approaches this issue from the perspective of persons with physical disabilities (see, e.g., Glass and Soni, 1999, discussing, inter alia, hidden impairments, deteriorating conditions, difficulties in reaching orgasm, and difficulty with ejaculation), but much less attention has been paid to persons with mental disabilities. As we have discussed extensively, the pernicious power of sanism's stigma has a universally chilling effect on the ability of this population to achieve sexual autonomy.

Historically, our views on sexuality have evolved and changed; however, society in general continued to hold on to Victorian notions of repression and confinement of sexual behaviors. As Michel Foucault wrote in *The History of Sexuality*, "the legitimate and procreative couple laid down the law" (1978). While there have been minority groups and sexual liberation movements over the past century that have challenged the notion of sex as confined to the procreative couple, Western society has generally continued to embrace the Victorian model when it comes to personal sexuality, or when setting rules for the sexual expression of others.

However, society has not always been so repressed and tight-lipped about sexuality in general. Before the Victorian era of confined, quiet sexuality, seventeenth-century society was more frank and open about sexuality and its acts. The change into a more sexually repressed society did, however, retain some of the freedom of the early seventeenth century (Dabhoiwala, 2012); today, we publicly see and accept sexuality in advertising, television, and movies often without batting an eye. But those are strangers engaged in that in-your-face sexuality, not connected to our own individual day-to-day sexual experiences and desires, which society continues to uphold as personal, private, and still, to some extent, the domain of the procreative couple.

The philosopher Patricia Marino reminds us that, before the twentieth century, cultural attitudes about sexual ethics were framed largely in terms of "appropriateness and chastity: sex between a man and woman who were married was appropriate, other sex was not, and chastity meant governing one's sexual impulses in a way appropriate to those norms" (2014, p. 22; compare Peakman, 2013, p. 7, concluding that, in the longer arc of history, sexual behaviors now considered "abnormal" were deemed to be acceptable). At this point in time, Marino continues, "it is no longer philosophically plausible to say that sexual activity is morally wrong simply in virtue of being homosexual or that some kinds of sex are simply 'perverted'" (2014, p. 23). But it is necessary to underscore, again, that this sea change that Professor Marino accurately identifies has had little impact on the question that we are confronting in this book: the sexuality of persons with disabilities.

Professor Peakman's review of what were considered to be "standard" sexual practices to the ancient Greeks and Romans "[laid] down the laws of what was permissible sex and what was not" in a way that would influence attitudes about sex for "centuries to come" (Peakman, 2013, p. 25). She also reviewed how, prior to the end of the nineteenth century, the meaning of "unnatural acts" was "something quite different from our current understanding" (id., p. 18), and further, how the influence of the Church's teachings (in particular, Aquinas's views that oral and anal sex—in a consensual, marital relationship—were "worse than rape" because they "us[ed] the wrong vessels," id., p. 25, quoting *Summa Theologica,* Arts. 1, 12) had dominated public attitudes for centuries. His writing on the origins of these beliefs transformed our discourse about sexuality and set the standard for many modern beliefs about sexuality. The vast differences between what was acceptable and taboo then, and how each of those categories have changed over time, is a fascinating study of culture, society, and religion, and how each can shape sex—such a basic human function—into what we see today.

In an analysis of the history of marriage in Mesopotamia, Lars Nelson tells us that, in ancient times, "religion was unrelated to law and marriage" (2013, p. 1060) and that marriage was understood "as a heterosexual, monogamous-ish, contractual relationship that had a tendency to yield children" (id., p. 1064); however, subsequently, as part of his need to "mollify . . . his empire," Hammurabi, as part of his governing Code—drafted to promote the moral, political, and legal values of government (Jackson, 2010)—enacted provisions to protect marital fidelity and to preserve economic resources within families (id., pp. 1070–71). The changes had a lasting impact on that society and carried through the centuries. Even today, the United States faces criticism from many citizens who believe religion is far too entrenched in the legal concept of marriage. Marriage has transitioned from that contractual relationship in Mesopotamia into a pillar of morality held up by members of both government and religious groups who extol its sanctity:

> According to widely accepted religious tenets, "the highest earthly goal of human beings was to enter into marriages through which children would be produced. Centering human welfare on marriage, the [Catholic] Church held that the only non-sinful form of sex was procreative sex between a husband and wife." (Linn, 1999, p. 752, quoting, in part, Eskridge and Hunter, 1997, p. 136)

A. Contemporaneous Attitudes

In spite of all of the changes toward expressions of sexuality in the late twentieth and twenty-first centuries, taboos remain. These are especially prominent with regard to sex that is not viewed as mainstream (or, as discussed in this book, sex of any kind that is engaged in by people who are not viewed as a desired population).

Brennan Thomas Hughes concludes that "Western society persists in viewing certain sexual relations as 'unclean,'" an uncleanness that "may subconsciously be associated with the 'dirtiness' sometimes ascribed to lower classes and other races" (2015 p. 59). Consider this side-by-side with what one of the coauthors (MLP), over 20 years ago, characterized as one of the basic sanist myths (see Chapter 2): "[Persons with mental disabilities] smell different from 'normal' individuals, and are somehow worth less" (Perlin, 1992b, p. 393). These views of the "other" as being somehow distinguishable and different allow sanism and biases to continue to be prominent in discussions of nonconforming sexuality, in particular. And, when the person viewed as an "other" is engaging in—or even expressing desire to engage in—these nonconforming acts, the biases are doubled.

There is an uncanny parallel here with an exercise in an abstinence sex education program in Mississippi:

> The “Cookie Exercise” involves having four student volunteers each spitting a chewed-up Oreo cookie into a cup of water and then swapping cups with other students. A fifth student holds a clean cup of water. The entire class is asked which cup of fluid they would rather drink. According to the lesson, the four students represent sexual activity while the fifth represents purity. “The messages of this exercise are clear. Young people who have had sexual intercourse are dirty; they are the equivalent of spit.” (Caputi, 2011, p. 312, quoting, in part, SIECUS, 2010, pp. 20–21)

This message of filth versus purity also extends to individuals who society holds to be inappropriately engaging in sexual behaviors, like people with disabilities. The general public holds two competing stereotypes of sexual behavior of individuals with disabilities—hypersexuality or asexuality—but ultimately they each represent an abnormality or anomaly, rather than the pure, clean norm.

This book also considers the concept of the ways in which disability intersects with other characteristics throughout these chapters, and it is particularly important to understand how it affects the sexual autonomy of individuals with disabilities. The combined stigmas associated with disability and sexuality can, when felt together, create an incredible sense of isolation and loneliness. Additionally, if an individual already in the throes of these stigmas also happens to express opinions or desires that are outside mainstream sexuality, he adds yet another intersecting bias and must face a society that is generally unwilling to accept what it views as deviant sexuality.

However, there is some hope in the academic community. Scholars are beginning, finally, to seriously consider the impact of the stigma associated with mental illness on the sex lives of persons who are mentally ill, and the abject level of isolation felt by so many in this cohort. A study by Professor Eric Wright and his colleagues found that persons with serious mental illness have “unique concerns about sexual activity, many stemming from their being labeled as mentally ill and/or receiving psychiatric care” and that these concerns also raise important insights into how this stigma “can lead to individual and structural sexual discrimination as well as the psychosocial reorganization of the sexual self-concept” (2007, p. 92; see also, Cook, 2000, p. 200: “Partly due to their disorders and partly to societal stigma, people with psychiatric disabilities lack self-confidence and experience very low self-esteem that can impair their ability to establish intimacy with others”). People with disabilities, frequently having grown up in a societal context that “silences, devalues, and distorts their sexuality, have internalized many aspects of that negativity" (Shildrick, 2007, p. 57). Importantly, institutionalization has been seen as a major factor leading to this isolation in the community.

Many respondents to Professor Wright's survey simply noted that they could not have sex because they were "incarcerated," "locked up," or "institutionalized." Others referred to more specific aspects of their mental health treatment facility or program, such as regulations forbidding sexual activity while in treatment or staff instructions to limit or stop sexual expression. The respondents' comments within this theme generally reflect the most overt forms of structural discrimination. Of those who referred specifically to rules and sanctions, there was notable variation. According to respondents like this hospitalized man, in some treatment programs rules against having sex were clearly stated and enforced:

> There is no way to have sex in here. They check rooms every so often and you don't know when they are going to come in . . . I think if you get caught you end up in one of the seclusion rooms for a while. I would lose my buildings and grounds pass . . . (Wright et al., 2007, p. 92)

Elsewhere, staff attitudes toward sexual expression were more implicit. As one woman noted, "It is common knowledge that at a group home you don't do anything (sexual) . . . They didn't say anything, but the point is obvious" (id., p. 90). The authors concluded that opportunities for sexual expression were limited by the structural discrimination resulting from the restrictive sexual culture of their treatment settings (id.).

A valuable parallel might be drawn between these situations and what scholars have focused on in the related areas of gay rights law and antidiscrimination law related to community residences for persons with disabilities: combating animus (see Developments in the Law, 2014). In *Cleburne v. Cleburne Living Center,* 1985, the US Supreme Court struck down a local zoning ordinance that had sought to bar congregate housing for persons with intellectual disabilities, holding that "private biases may be outside the reach of the law, but the law cannot, directly or indirectly, give them effect" (*Cleburne*, p. 448, quoting *Palmore v. Sidotti*, 1984, p. 433). When read alongside certain gay rights cases (e.g., *Lawrence v. Texas*, 2003, striking down state consensual sodomy statute) and government benefits cases (e.g., *United States Department of Agriculture v. Moreno*, 1973, striking down federal law excluding households with unrelated adults from being eligible for food stamps), this grouping stands for the proposition that "freedom from animus is becoming a freestanding—and probably generalizable—constitutional principle, firmly grounded in overlapping due process and equal protection concerns" (Developments in the Law, 2014, p. 1769).

Certainly, persons with disabilities who seek to exercise sexual autonomy are the targets of animus; recall the story that began this book (the woman on the train saying it was "disgusting" that someone *wrote* about persons with disabilities having sex). As Professor Elizabeth Emens has underscored:

> In contrast to the domains of sex and race, and even physical disability, where overt hostility and dislike have arguably diminished to some extent, or at least gone underground by morphing into less conscious forms of discriminatory animus, overt animus against people with mental illness is not uncommon. (2006, p. 410)

B. Enjoyment of Sex/Desexualization

The sexuality of persons with disabilities "remains shrouded in myths and prejudice" (Franco et al., 2012, p. 261, discussing persons with intellectual disabilities). Are people with disabilities "allowed" to enjoy sex? Think back to the anecdote we shared in the introductory chapter about the manager of the facility in California who was willing to allow the residents in that facility to have sex for two hours on Saturday because that was when he and his wife had sex. The message is clear: This population dare not *enjoy* sex more than we (those without overt mental disabilities) do.

A family planning NGO in Victoria, Australia, has put it simply:

> Sexuality is a key part of human nature. Expressing sexuality in satisfying ways is important for everyone, including people with intellectual disability. Some people with intellectual disability may need additional support, education or services to enjoy healthy sexuality and relationships (Better Health Channel, 2015, http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Intellectual_disability_and_sexuality?open).

In the contemporary Western world, however, considerations of sexual pleasures and sexual desire in the lives of people with disabilities "play very little part in lay consciousness, and practically none in social policy" (Shildrick, 2007, p. 53). This can be due to true ignorance—forgetting to consider this population—or a more directed effort to keep this population from engaging in sexual activity like their nondisabled counterparts, borne from desires to regulate the activities of individuals who do not appear "capable."

There is also an important gendered element inherent in this discussion. Even within the population of individuals with disabilities, there are different standards based on whether the participant is male or female.

As Professor Beth Burkstrand-Reid notes, for women, "sex for pleasure, for fun, or even for building relationships is completely absent from our national conversation" (Burkstrand-Reid, 2013, p. 213, quoting Valenti, 2009, p. 43).

This is true for both disabled and nondisabled women; however, disabled women then have the addition of their disability contributing to the already-present bias against their sexuality. In at least one New York City hospital, male patients leaving the facility on unsupervised community leave were given condoms upon request. Female patients, on the other hand, had to have their competency (informally) assessed before birth control pills can be prescribed (Perlin, 1993–94, p. 541). Notes Bethany Stevens: "Disabled people face structural and attitudinal barriers when seeking sexual and reproductive autonomy; paying for pleasure is the consequence of punitive medical and legal systems in the United States" (2011, p. 14). Jacob Appel states bluntly, "We must begin to see sexual *pleasure* as a fundamental right" (2010, p. 154).

Scholars are beginning to consider seriously what is being called *desexualization*: "(1) shaming sex for pleasure and (2) reinforcing a norm that sex should be for the purpose of procreation or, for women more specifically, motherhood" (Burkstrand-Reid, 2013, p. 224). Staff at residential facilities have traditionally desexualized adults with learning disabilities through the withholding of information and through punishment (Yool et al., 2003). Professor Burkstrand-Reid argues that the law minimizes "the importance, or even denies the existence, of women's desire for sex for pleasure and then re-characterizes women's sexual actions as implicit acceptance of motherhood," repeating "the age-old division of women into Madonnas and whores" (Burkstrand-Reid, 2013, p. 223; for a historical perspective, see Wouters, 2010).

Like a laser, Professor Elizabeth Emens hones in on desexualization in the context of our inquiries here, noting that important recent work in disability studies has called attention to the desexualization of persons with disabilities (2009, p. 1335). She notes the contradiction of stereotypes referred to earlier in this work—sometimes, "disabled people seem presumptively hypersexual, rather than nonsexual" (id.), noting that "such attributions of heightened or uncontrolled libido again serve as a justification for denying the sexuality of disabled people—to prevent them from imposing their sexuality on others and potentially tainting the human race" (id.). Similarly, Rhonda Neuhaus has noted, "Women with disabilities may be stereotypically perceived as asexual or hypersexual, neither of which form the complete picture of the actual needs of women with disabilities" (2012, p. 90). Whether one is treated as asexual or overly sexual, the end result is the same sexual alienation (see, e.g., Gupta, 2015, and Kim, 2011). Consider some of the rhetorical questions articulated when the idea of persons with intellectual disabilities having sex is raised: Would they have sex at the first opportunity? Would men become hypersexual without any control over their impulses? Would women start to breed compulsively? (Kempton, 1978)

The courts are complicit in this desexualization. Emens quotes a federal district court opinion discussing what kinds of relationships regulations promulgated under the Americans with Disabilities Act assumed that disabled people would have:

> As the regulations make clear, the ADA's purpose is to prevent discrimination against . . . those who may have a close familial, social, *or possibly even* physical, relationship with a disabled person. The paradigmatic case is that of the parent of a disabled child, whose employer may fear that the child's disability may compromise the employee's ability to perform his or her job (*O'Connell v. Isocor Corp.*, 1999, p. 653; emphasis added).

Appropriately caustically, Emens concludes that a "disabled person paradigmatically would have a parent, and may have a 'social . . . relationship.' But a physical—that is, sexual—relationship is presented as almost inconceivable: 'possibly even'" (2009, p. 1330).

But, of course, this is not the way it should be. Professors Julie Tennille and Eric Wright have thoughtfully and sensitively addressed the intimacy needs of persons with disabilities. Their observation that "individuals with mental health conditions face additional obstacles to exploring their sexuality and forging satisfying intimate relationships" (2013, p. 2) and their focus on the "false assumptions" made by many care providers about the "fundamental importance of intimacy to consumer well-being" (id., p. 9) must be "center stage" for this entire investigation (Perlin and Lynch, 2015b, p. 15).

Julie Tennille and others of her colleagues emphasize that "many providers continue to hold outdated views of clients as asexual, exclusively heterosexual, or believe, paternalistically, that clients with psychiatric disabilities will decompensate and require hospitalization if they date or become sexually active" (Tennille et al., 2014, p. 472). Consider the list of myths and false beliefs held frequently by care providers about the sexuality of persons with mental disabilities:

- Consumers are asexual;
- Only "young" consumers are interested in sexuality;
- Consumers who are sexual are heterosexual;
- Providers can quickly assess if a consumer is gay or lesbian;
- Only medical professionals are qualified to address this topic;

- Consumers inform their doctor about sexual side effects;
- Only consumers who are "promiscuous" need information about safer sex;
- It is the providers' role to protect consumers from romantic rejection; and
- Dating and/or becoming sexually active will compromise the stability and progress consumers may have made (Tennille and Wright, 2013, pp. 8–9).

Also, a recent article about the role of care providers for persons with neuromuscular disorders strongly recommends that such providers facilitate sexual expression in all patients, "regardless of their level of impairment" (O'Dea et al., 2012, p. 172; on similar recommendations for patients with spinal cord injuries, see Pebdani et al., 2014), recommendations that are at odds with the attitudes of such providers that typically leave consumers "feeling ridiculous and embarrassed" (id., p, 182).

Ironically, almost completely missing from the literature is any consideration of how persons with disabilities themselves feel about their own sexuality (see Hall and Yacoub, 2008); this irony is magnified in the context of the full participation of persons with disabilities in the negotiations that led to the ratification of the UN Convention on the Rights of Persons with Disabilities, supported by their "clarion cry, nothing about us, without us" (Perlin, 2012, p. 20; Kayess and French, 2008, p. 4, n. 15). It is imperative to broaden our understanding of how individuals with disabilities feel about their own sexuality, breadth of experiences, and identities. Without a concerted effort to reach out to this group, it will be difficult to conduct any kind of meaningful examination that can lead to improvement in the sexual autonomy of persons with disabilities.

Our understanding of sexuality comes from a shared history and understanding of what is appropriate based on our roles in society. This understanding has been ever-evolving, and must be understood in the context of other fluid constructs such as gender identity and gender roles. Individuals with disabilities must not only fit into the role of what a "disabled person" should do, say, and want, but they are also often forced to assume what others believe are appropriate gender roles that will ultimately dictate what they learn and how they are able to express a desire for sexual activity.

II. Gender Attitudes and Sexuality

It would be impossible to write a book about sexuality, regardless of *whose* sexuality we were discussing, and not talk about the significant intersection with gender, historical attitudes, and identity politics. From the repressed

Victorian notions of sexuality to the hypersexualized advertising surrounding us today, we are a society that has had an ever-changing relationship with our own desires and our policing of the ways in which other people express their desires. Our relationship with sexuality and disability is even more convoluted, repressed, and hypocritical.

Gender has, now more frequently than ever, been identified as a construct, or a notion created by culture and society. Historically, the term "gender" was adopted as a means of distinguishing between biological sex and socialized aspects of femininity and masculinity (Marecek et al., 2004). These aspects of male and female identity become tied to the socially constructed gender bestowed upon an individual at birth, and that individual grows up internalizing cues and requirements for being a member of that gender and performing gendered activities reserved for either men or women. Any individual who rebels or fails to follow gender norms is nonconforming and that can lead to assumptions about the "validity" of gender identity. However, the concept of gender identity should not be taken as static; rather, gender identity is fluid and can change throughout the course of one's life (West and Zimmerman, 1987).

Our society has relied heavily on these gender identity roles and stereotypes, so much so that we have integrated them into many aspects of our lives. Of particular interest to the coauthors is the gendered nature of the legal system, especially present in the ways in which girls and young women, both with and without disabilities, enter the juvenile justice system. Historically, girls and young women were far more likely to be brought to court for "premarital sexual conduct or other 'morals' violations" (Godsoe, 2014). Today, very little has changed. Girls, due only to the gendered nature of the juvenile justice system and the gender biases at play for judges who oversee hearings and sentencing, are still disproportionately brought to court on a status offense for a sexual conduct crime (id.).

The gendered nature of our legal system, which has remained surprisingly unchanged since its modern inception, is just one example of how prevalent gender identity and proscribed gender roles have become in modern society. Many of our current views on gender, sexuality, and expression of sexuality have their roots in religious attitudes long-held in many different religious traditions; Professor Claire Smearman makes the point explicitly: "The present day conservative view that associates birth control with sexual promiscuity can be traced to the historical treatment of female sexuality by the Christian religion" (2006, p. 497).

Western thinking and attitudes about sex and sexual pleasure can be traced back to the Greek dualism, juxtaposing the soul and body. Pleasures of the flesh were ranked as the lowest of goods, and Plato relegated sexual desire to "the lowest element of the psyche" because, he observed, "copulation lowered a man to the frenzied passions characteristic of beasts" (Tepper, 2000). Later, the Catholic Church adopted many of the Greeks' philosophical tenets about bodily pleasures and, over time, strengthened the negative attitudes and beliefs about sexual pleasure, eventually coming to view pleasure derived from sex as its own sin. Then, the Puritans and later the Victorians in the late 1700s to mid-1800s introduced censorship based on sexuality, giving Western culture the first system of laws against "obscene" or objectionable words including any direct reference to sexual matters (id.).

There is, as John Cochran and Leonard Beeghley write, a "long-standing Judeo-Christian doctrine of asceticism and related traditions restricting sexual activity to married heterosexual couples" (1991, p. 45). Roots for this can be found in dominant religions, and in the teachings of New England Puritans, whose religious doctrines reinforced the Victorian ideals of sexuality being private and between procreating couples. Even today, our societal attitudes about sexuality draw from these traditions and continue to be dominated by the religious view that sexual desires are to be "restrained" and sexual pleasures should be "avoided" (Davidson et al., 1995). In most Christian traditions, "sex is inherently sinful. It may be redeemed if performed within marriage for procreative purposes and if the pleasurable aspects are not enjoyed too much" (Rubin, 1984).

Further, traditional Christian theology holds that postlapsarian human sexuality generally is the mark of our shame for Original Sin. The permissible institutions for women's sexuality, in particular (i.e., marriage and legitimate motherhood) are humiliating punishments for Eve's role in instigating the Fall (Schroeder, 1992). The pleasure derived from sexual activity is particularly vilified in religious doctrine, with religious institutions taking on a "don't ask, don't tell" policy of discussing the fact that sex is a pleasurable experience (Tepper, 2000). In effect, starting from our abstinence-only sex education and ending with the complete lack of regard for the sexual pleasure of individuals with disabilities, "the dominant cultural institutions have effectively silenced public discourse of sex as a source of pleasure in our lives" (id.). Particularly relevant to this discussion is the role that religion plays in female sexuality. As J. Kenneth Davidson and his colleagues write, "The degree to which religiosity actually influences the sexuality of women remains a matter of conjecture" (Davidson et al 1995). Given the lack of knowledge, we can only assume an even greater dearth of information exists when examining the confluence of religious attitudes and their impact on the sexuality of individuals—particularly women—with disabilities. Since gender identity as a construct is fluid in nature, we expect that changes based on religion, modern culture, and ever-increasing awareness of the needs of different populations will continue to impact how we view gender and sexuality.

Compared to the fluid nature of gender identity, human sexuality has maintained a relatively stable definition throughout history, referring to "all sexual attitudes and behaviours in an erotic, or lack of erotic, nature" (Peterson, 2010). Sexuality and gender, however, is anything but stable. Instead, the relationship between one's gender and sexuality is an ever-changing, evolving one. Gender is often used to help define sexuality, as it provides a framework for understanding sexual desires based on the preferences of people within a particular gender. In many ways, one's gender identity determines how one learns and what one knows about sexuality.

When examining the role of gender as it relates to sexuality and disability, it is interesting to see that, even when disability is added to the conversation, many thoughts about the role of sexuality for individuals with disabilities divide based on gender roles. For example, some may argue that males and females have allegedly different physical needs—for example, some argue that males require different types, frequency, or intensity of sexual experiences than women. This is a belief held by those both with regard to individuals with disabilities and with regard to the population generally. Some examples of commonly held gendered beliefs about sex are:

- Sex is only physical for men, and only emotional for women;
- Sex is more important for men than women;
- Women's physical appearance is important; and
- Sexual desire and/or pleasure does not significantly apply to women. (McCabe et al, 2010)

These were provided in a study by individuals who were not given cues about what answers the researchers were looking for. The overarching theme present here is that men get more out of sex—it is more important to them, and they get greater pleasure from it.

Interestingly, we see these stereotypes about sexual activity held by the general public applied to individuals with disabilities as well. This is, of course, all overlaid by the unique stereotypes applied to persons with disabilities (hypersexual or asexual based only on disability). However, the little research that has been done on the complexities of sexual desires of persons with disabilities shows that not only do people with disabilities express the same wide range of interests and desires as nondisabled peers, but the gendered dynamics assumed for all members of society do not seem to be accurate, either. In one study, researchers found that 94 percent of women with disabilities who surveyed were sexually active at some point and reported as much sexual desire as other women in general (Nosek et al., 2001).

However, there are still formidable stereotypes standing in the way of allowing these individuals, particularly women, to address their individual sexual desires. While sexual liberty has "increasingly come to be regarded as a basic human right," there are still unique obstacles faced by individuals with disabilities who may want to engage in sexual activity, including the gender imbalance of available services, and the difficulties these individuals will likely face if they need any kind of assistance in engaging in sexual activity (Appel, 2010).

Facilitated sex is not something that the general public often encounters, especially in the Western world. However, for individuals with disabilities, it may be the only way in which they are able to engage in desired sexual behaviors, based on their physical limitations (id.). The White Hands service (see Chapter 4) is an interesting example of the positive benefits of facilitated or assisted sex for individuals with disabilities, but also an illustration of the ongoing gender dynamics at issue with regard to the sexual needs and desires of men versus women. The service, based in Japan, bills itself as an agency with the specific purpose of helping people with disabilities who cannot perform the act of ejaculation (http://www.whitehands.jp/e1.html). The care staff of White Hands will travel to an individual's home and perform a genital massage with the specific goal of facilitating ejaculation. White Hands makes clear that its goal is to "protect the dignity and sexual independence" of individuals with disabilities.

However, White Hands limits its clients to men. They are explicit in differentiating between male ejaculation, which is "simple," and female orgasm, which is "infinitely more complicated." White Hands staff acknowledge that they have received questions about whether a comparable service for disabled females is available, and they state that there is not and that they have not pursued this option because they "haven't received any requests" from women with disabilities interested in this service. They continue, questioning "what kind of service would be appropriate" for potential female clients, and stating that no one has had a satisfactory answer as of yet (http://www.whitehands.jp/e1.html).

This limitation can be understood in two ways. The first is that women likely are not seeking out this service. However, the more interesting question here is why that is the case. If studies show that a high percentage of women with disabilities report the same sexual desires as nondisabled peers, then why has no one come forward and started a conversation about female-centric facilitated sex services? Recall the bullet points taken from the McCabe et al. study (2010), however; both women and men have been taught that explicitly seeking out and finding outlets for one's sexual urges and desires is a male trait, because, based on the stereotypes ingrained in our society, men are the ones who enjoy sex and, put simply, need sex. There may be other factors at play here given the cultural differences between the United States, where the McCabe study took place, and Japan, where White Hands is located. However, it is clear that across cultures there is an ever-present gender-based belief about who needs and deserves assistance in engaging in sex.

Similarly, in Sweden, laws regarding facilitated sex allow for disabled individuals to seek assistance in order to maintain "autonomy, integrity and self-determination" (Bahner, 2012). However, individuals with disabilities who were interviewed by Julie Bahner and her colleagues raised issues with the availability and methods of these services, stating that they still had problems being recognized as "a sexual being" by caregivers and that different physical limitations have presented obstacles to sexual expression (id.).

Facilitated sex continues to be a fairly radical idea in many countries around the world. Those that do embrace it and regulate it often do so based on provision of the Convention on the Rights of Persons with Disabilities. However, there is still a long way to go in creating services that not only allow disabled individuals the same rights and experiences as non-disabled peers, but that also address the ever-present gender imbalances that are part of many of the conversations about this issue, and the services themselves. As Sarah Earle writes, "denial of sexual identity is a significant feature of power relations" and women are already at a disadvantage in terms of power, with men frequently trying to regulate how female bodies are viewed and used (Earle, 2001). Repressing sexuality in women with disabilities adds to the loss of power women already face simply by being female and by being disabled.

While many nations, regardless of cultural specifics, view sexuality through a gendered lens, there are exceptions. It is particularly interesting to look outside the United States and examine the ways in which other cultures define and represent gender. Since gender identity is a social construct, individual societies have vastly different identities that typically match with a particular gender.

III. Abuse of Persons with Disabilities

There is no question that persons with disabilities suffer a disproportionate amount of physical and sexual abuse (e.g., Haddad and Benbow, 1993; Bowers and Veronen, 1993; Murphy et al., 2007). This problem is compounded by the fact that neither police nor caregivers nor health and social service departments take this cohort of victims seriously enough when abuse is reported (Murphy et al., 2007). Moreover, research shows that there is a need to educate people with intellectual disabilities about the laws relating to sexuality, so that these individuals better understand the law; given the high rates of sexual abuse perpetrated against people with intellectual disabilities, it is essential for them to benefit from the protection the law affords (O'Callaghan and Murphy, 2007). There is thus additional responsibility on caregivers—especially nursing staffs—to help them understand the consequences of unwanted sexual contact (Thompson, 2011), and the legal implications of such abuse (O'Callaghan and Murphy, 2007).

IV. The Special Issues Raised in Cases of Individuals with Autism

As we noted previously, we were startled last year when we read, in a scientific academic work, "The recognition that individuals with disabilities have a *desire* for sexual relationships with other people is a relatively new concept in the scientific community" (Perlin and Lynch, 2014, p. 258, quoting Gilmour et al., 2014). The book in which that chapter appeared was titled, *Comprehensive Guide to Autism*, and the chapter to which we referred leads to these question: What about persons with autism? Where do they "fit" in this entire investigation? It is significant that a major article about autism and sexuality is titled, "'I'm Not Sure We're Ready for This . . .': Working with Families Toward Facilitating Healthy Sexuality for Individuals with Autism Spectrum Disorders" (Nichols and Blakeley-Smith, 2009).

Autism spectrum disorders (ASDs) include a range of conditions that are characterized by difficulty with communication and social interaction, repetitive behaviors, and a tendency toward narrow, focused interests. The surprise reflected in the chapter quoted above should *not* have been a surprise. There is no question that "individuals with autism are sexual; they are interested in sexuality, have sexual needs, and oftentimes want to develop relationships with others. Moreover, individuals with autism display a wide variety of sexual interests and behaviors. In other words, sex matters" (Gougeon, 2010, p. 328). In fact, although there *are* persons with autism who appear to be asexual, research tells us that most individuals with ASD display an interest in sex and engage in sexual behaviors and showed no significant differences in breadth and strength of sexual behaviors and comprehension of sexual language when contrasted with persons who had not been diagnosed with ASD (Gilmour et al., 2012), and thus, of course, the majority of this cohort "desire sexual relationships" (Gilmour et al., 2014, p. 580).

There has been, however, very little applied research in this area—little research on romantic relationship difficulties, on long-term relationships and marriage, on the contours of the meaning of consent to this population (id., p. 579). Perhaps, as in the Sherlock Holmes story (of the dog that did not bark in the night), this *lack* of research is the most telling information to share. Is it because even *researchers* could not conceive that this was a topic worthy of study because their false "ordinary common sense" (see Chapter 2) told them that this population could not be sexual?

V. Impact of Disability on Sexual Functioning

Incredibly underdiscussed areas in literature surrounding disability and sexuality are (1) the actual physiological impact disability can have on sexual functioning, (2) the medical alternatives to loss of function, and (3), on a more personal level, what particular individuals can do to otherwise express their sexual desires..

We previously discussed the effects that psychiatric medication can have on sexual function (see Chapter 3) and noted that there is very little reliable, medical literature on the numbers of individuals who report sexual dysfunction as a side effect and seek out alternative treatments based on that. However, we have found that there is even less scholarly interest—especially and pointedly, in a legal context—in a discussion about how the disability itself can serve as a barrier to sexual autonomy.

There has been some work in the autism community on this issue; however, it is frequently linked with criminality (Berryessa, 2014 and physiological functioning (Gilmour et al., 2012). It is particularly interesting to note that the known research aligns with the increase in advocacy, and particularly self-advocacy, for this population. Individuals with autism spectrum disorders (ASD) have become more and more vocal about their needs and desires, which has included sexuality and sexual preference. Self-advocates, like Laura Gilmour, write openly about their own experiences and views. While there may be continued stigma directed toward this population, they are actively working to overcome it by contributing their voices to the discussions about them. In other realms of mental disability, this type of advocacy and integration is not as developed; this may explain why much of the research that deals with the actual experiences of individuals with disabilities comes from the ASD community specifically.

Gilmour raises interesting issues about how disability—specifically ASD—may impact sexual autonomy. In 2014, she and her coauthors released the *Comprehensive Guide to Autism*, which included the assertion that people with ASD have sexual interests and engage in sexual behaviors with others (Gilmour et al., 2014). In a prior article, Gilmour considered this question in greater depth, saying that although individuals with ASD display an interest in sex, engage in sexual behaviors, and show no significant differences in breadth and strength of sexual behaviors and comprehension of sexual language, a higher rate of asexuality was found among individuals with ASD when contrasted with non-ASD individuals (Gilmour et al., 2012). Researchers continue to not only acknowledge that individuals with ASD are desiring of sex, but also to contribute to a deeper understanding of how ASD can affect sexual relationships. A 2015 study by Denise Kellaher opened with the assertion that the continued collection of data on this subject "is dispelling antiquated notions that ASD individuals are asexual, sexually unknowledgeable and inexperienced, and/or disinterested in relationships" (Kellaher, 2015).

Beyond the specific issues faced by individuals with ASD, there are equally complex questions raised about how individuals with other mental and physical disabilities overcome specific problems related to their sexuality or ability to engage in sexual activity. Psychologist Clive Glass and a colleague created a list of all the possible ways that disability, either directly or indirectly, could affect sexual activity, including direct trauma to the genital area through accident or disease, damage to or dysfunction of the nervous system, and disability that causes fatigue that can indirectly affect an individual's arousal, desire, or ability to engage in sex (Glass and Soni, 1999). They also highlighted the psychological effects of disability on sexual activity, noting specifically that "dependence on others" and "one's own self-image" can have profound effects on ability to engage in sexual activity, even if the individual has no physical barriers (Glass and Soni, 1999, p. 107).

A common theme among many articles and studies that discuss sexual performance and disability, authored both by self-advocates and researchers, is that of intimacy as it relates to sexual function. This is an important component of sexuality research, because it highlights a desire, unrelated to the act of engaging in sex, to which individuals without disabilities can also relate. In a way, bringing the discussion of intimacy into the conversation may serve to "humanize" the literature about sexuality and disability, just as talking about quality of life for individuals with disabilities brings that conversation out of the purely medical or clinical realm. One study that examined the issue of intimacy found that, when individuals with physical disabilities completed the Sexual Knowledge, Experience, and Needs Scale (see McCabe and Cummins, 1996), the strongest associations were between sexual intimacy and quality of life (McCabe et al, 2000).

Emotional and psychological effects on sexuality can also be exacerbated by non-disability-related circumstances, such as a history of sexual abuse. Research indicates that family members and caregivers for individuals with intellectual disabilities who have suffered abuse need to be aware of behavior patterns that emerge after the abuse (Murphy et al., 2007). In some of those instances, this can include sexual behaviors, and it is important to acknowledge the meaning behind those behaviors, rather than assume based on stereotype that sexuality or asexuality is simply a function of the disability itself (id.). However, caregivers and family advocates are taking note of the difficulties that may be present when an individual with a history of sexual abuse and an intellectual disability wants to engage in sexual activity. David Thompson wrote a guide for nurses and caregivers that carefully reviewed the history of sexuality among individuals with intellectual disabilities, and presented practical guidelines for how to assist individuals who want to make the choice to have sexual relationships. According to Thompson: "Opportunities for people with learning disabilities to have sexual relationships have changed enormously," so it is critical that the literature continue to be up-to-date and respectful of the dramatic ways that this area has evolved (2011).

While the emotional and psychological elements of disability can be detrimental to an individual with the desire to engage in sexual activity, physical barriers can be equally hindering and can produce some of the psychological consequences discussed above. The two broad categorizations of the emotional and the physiological need to be viewed as interconnecting factors, rather than separated, medicalized, and ignored.

VI. Facilities Other Than Psychiatric Hospitals

As discussed earlier in Chapter 3, the types of facilities in which individuals with disabilities live run the gamut in terms of policies and the populations encapsulated within them. While this book generally focuses on facilities such as psychiatric hospitals and facilities for individuals with developmental disabilities, issues of sexual expression are not limited to these institutions. Nursing or assisted-living facilities, jails, prisons, and group homes may present unique challenges in terms of policy making and regulating sexual activity that come about based on the specific populations they serve.

The individual populations in each facility also dictate, to some extent, the types of policies enacted. This has to do with intersecting stigma based on mental disability and whatever additional factors lead that individual to need facility-level care or supervision. For example, individuals in forensic facilities not only face the stigma of being identified as a person with a mental illness, but also face bias based on their status in the criminal justice system (Perlin and Schriver, 2013). This translates to policies on sexuality that take these intersecting biases into account. The classification of "dangerous" that may be placed upon a justice-involved, mentally ill criminal defendant would apply equally to his desire to engage in sexual activities, so facilities like forensic psychiatric units may be more likely to impose stricter regulations on its residents.

Individuals who live in facilities may face greater challenges based on their intersecting identifications, so it is important to "call out" ways in which these biases may manifest for each unique type of facility.

A. Issues in Jails and Prisons

Individuals with disabilities in jail and prison have a markedly difficult time expressing sexual autonomy, due to several factors that may be less prevalent in psychiatric facilities or developmental centers. In most prisons in the United States, there are strict prohibitions on masturbating, regardless of an inmate's status as a person with a disability (Cusack, 2014b). One rationale for this policy is that since prisoners have very little right to privacy, or private time generally, masturbation would necessarily take place within view of others, and that practice is socially unacceptable in the general society (id.). Since prisoners in general are viewed as potentially sexually threatening if allowed to masturbate (id.), there do not appear to be dramatic differences between policies for prisoners with and without disabilities: The policy is universal and it prohibits masturbation and consensual sexual contact across the entire facility.

Inmates with mental illness, however, may be unnecessarily harmed by these policies in a different way. Many individuals with mental illness who are incarcerated have a difficult time adhering to the strict rules and regulations of prison life (Fellner, 2006). In fact, they may be disproportionately punished for rule violations based on behaviors that are actually symptomatic of mental illness (see, e.g., Human Rights Watch, 2015, charging that jail and prison staff regularly use "unnecessary, excessive, and even malicious force against prisoners with mental disabilities"). In the case of sexual expression, an individual with mental illness may have a more difficult time recognizing and avoiding displays of sexuality, such as masturbation, based on his particular mental illness rather than any kind of depraved sexuality with which society may be concerned.

B. Conjugal Visits

Conjugal visits have generally been considered a privilege rather than a right (Wyatt, 2005). They are also seen as a potential "solution" to the prison rape problem so often discussed in reference to male inmates (id.). However, few scholars writing about prison issues have transcribed this topic into the realm of conjugal visits as a way to allow appropriate sexual expression for the sake of pleasure, rather than as a means to an end. This also becomes difficult in the setting of a secure psychiatric facility, where inmates with mental illness may be receiving treatment. Since policies about conjugal visits and sexual conduct generally, are usually fairly restrictive, it seems unlikely that psychiatric patients would be given the right to conjugal visits for the sake of their own sexual pleasure. To the best of our knowledge, there has never been a litigated case involving conjugal visits in a psychiatric institution.

However, it may be reasonable to look at prison conjugal visit policies and adopt the rationale behind them for individuals in secure psychiatric facilities. Their status as receiving treatment for mental illness should not automatically mean that they must necessarily be barred from engaging in sexual activity; rather, there may be an appropriate way to implement conjugal visits and provide those individuals with the same rights and abilities that their peers in prison are granted.

C. Issues in Facilities for Intellectually Disabled Individuals

Expression and acceptance of sexuality has changed "enormously" over the past several decades (Thompson, 2011). This is particularly true for individuals with intellectual disabilities. Where any expression of sexuality was seen as nothing more than a manifestation of their disability (the hypersexuality stereotype, in particular), now there is greater recognition of the existence of autonomy, as well as a wide range of sexual expressions that are not disability-related, but rather are person-specific, just as they would be for any nondisabled individual. One study that sought information about sexual behavior and policies specific to state residential centers for individuals with developmental and intellectual disabilities found that sexual relations between clients was reported to occur "sometimes" or "often" by 63 percent of the facilities surveyed (Gust et al., 2003). The authors of this study concluded based on their data that sex education and monitoring of STDs would be important steps for administrators at these facilities. Not too long ago, a complete restriction on sexual activities would not have been uncommon. However, as we discuss, facilities may still be lacking sufficient guidelines and policies about how to allow for appropriate, consensual sexual encounters in these facilities, which can lead to confusion for staff and residents and a denial of opportunities to express sexual autonomy.

D. Issues in Nursing Homes and Assisted-Living Facilities

Nursing homes, while generally catering to elderly persons, may have a more diverse population in terms of age where individuals with disabilities are concerned. Individuals who have disabilities that require some kind of skilled nursing care will often end up in nursing homes, regardless of their age. So, while issues of nursing home sexuality are more often than not linked to the age of the residents, this is not always the case. In many instances involving individuals with disabilities, concerns about sexual autonomy in the nursing home are similar to those faced in other kinds of group living arrangements (Haijar and Kamel, 2003).

There is, however, an important intersectional category that merits discussion: the combination of being elderly and disabled. Each of these descriptors comes with its own set of stereotypes and biases, but, when paired together, they can have a profound impact on the quality of life an individual with a disability may have, including in the realm of sexual autonomy. In the United States and much of the Western world, views on sexuality in the elderly are dominated by stereotypical thinking, ignorance, and prejudice. Sexuality is seen as an attribute of only the youngest, most conventionally desirable individuals. However, sexuality and sexual autonomy are basic human needs that continue throughout life, so while they may vary as an individual ages, they should not be viewed by nursing home administrators as something that can be sacrificed in order for facilities to fail to implement rules or policies surrounding sex between clients (Hajjar and Kamel, 2003). However, these needs are frequently overlooked and ignored. Adding sanism to this confluence of societal attitudes only serves to further alienate individuals in nursing homes and ensure that they are unable to engage in entirely normal sexual activities.

As we have written before, we exercise such "social control" over those institutionalized in all types of facilities because of mental disability, and we ultimately can see that the suppression of all sexual desire and action is, in fact, a form of social torture (Perlin and Lynch, 2014). Many disability rights advocates have raised concerns on behalf of individuals in prison, developmental centers, nursing homes, and other group living facilities, saying that society views "the disabled" as undeserving of love and sex for pleasure, and that the mere concept of their sexuality and reproduction is viewed with repugnance. These advocates believe that caregivers and institutions have a responsibility to consider sexual desire and pleasure when helping people with disabilities live out their lives (Tepper, 2000, p. 285). Sexual autonomy and ability to express sexual desires and preferences should not be dependent on the type of care one is receiving, or the nature of one's confinement.

VII. And, Finally, What Do We Mean by Sex?

As discussed above (see p. 98), when one of the coauthors (MLP) first wrote about this precise issue, he asked this question rhetorically:

> Do we need to consider every possible permutation of sexual behavior? Does it make a difference if we are discussing monogamous heterosexual sex, polygamous heterosexual sex, monogamous homosexual sex, polygamous homosexual sex, or bisexual sex? Does sex mean intercourse? What about oral sex? Anal sex? Masturbation? Voyeurism? Exhibitionism? Should erotic or pornographic material be made available to patients? If so, what sorts—magazines of the kind often available at convenience stores or "hard core" magazines generally thought of as "42nd Street fare"? What about sexually explicit literature that might appear to involve, condone, or encourage violence? Should sexually explicit videos or movies be available for patients to see? If so, should they view them communally or individually? What if a patient's prehospitalization behavior involved significant "sexual acting out" in what had been seen as inappropriate ways? Should a patient's decision to engage in what is sometimes perceived as "deviant" sexual behavior subsequently be used as evidence of their danger either to self or others or of "grave disability"? (Perlin, 1993–94, p. 527)

While some of these questions have been answered, and while there has been scholarly interest (mostly in nursing, psychological, and social work journals), many of these questions have still gone unanswered.

The core question, made famous during the *brouhaha* that captivated the United States in the late 1990s, when former President Bill Clinton was accused of having sexual relations with a White House intern, Monica Lewinsky, assumes significance in the topics under discussion in this book. Recall (see Chapter 3) the expansive list of what is proscribed at Napa State (Psychiatric) Hospital:

> Those behaviors determined to be illegal, unhealthy, disruptive or antagonistic as follows: open mouth kissing, oral stimulation of genitals (including breasts), anal stimulation or intercourse, sexual intercourse . . . promiscuous behavior . . . prolonged closed mouth kissing, intimate body to body contact, touching underneath clothing, touching of genitals (including breasts), exhibition of the body in any manner judged to be provocative and sexually solicitous. (Sy, 2001, p. 546)

Putting aside the anatomical questions that one might ponder as to whether breasts can be viewed as genitals, the serious question that remains is: "What's left?" The hospital policies *do* allow for:

> Brief hugs, kisses on cheek, brief closed mouth kisses on the lips, nongenital touching, holding hands, and noninteractive, self-stimulating behavior (masturbation) that occurs in private and is without offense or risk to the individual and/or other clients (id.).

In both instances, the author cites a hospital administrative directive (Turley, 1988, as cited in Sy, 2001), and there is no indication at all as to *why* the policy was drafted as it was, and what issues were weighed in creating this Maginot Line. But this is by no means unique. An earlier study suggested that staff, at a facility for persons with intellectual disabilities, "would 'tolerate' kissing or holding hands . . . but the expression of other sexual behavior would be discouraged" (Yool et al., 2003, p. 138, citing Haavik and Menninger, 1981). It is probably worthwhile to consider here a recent article—about a civil law suit that followed litigation over a long-term relationship between a man with a psychosocial disability (schizophrenia) and a priest with AIDS (Abramson et al., 2012)—that questions whether sex can be ordered like a "Guttman scale" (see Guttman, 1950; for subsequent considerations of this scale, see, e.g., Podell and Perkins, 1957; Cowart and Pollack, 1979; Cowart and Pollack, 1979)—in which items are arranged in an order so that an individual who agrees with a particular item also agrees with items of lower rank-order (see, e.g., Andrews et al., 1991; Mokros et al., 2011) involving a "unidimensional behavioral hierarchy from French kissing to penetrative intercourse" and wonders if "someone has consented to touching genitals over clothing . . . implies consent to French kissing," asking whether "consent to one step automatically insure[s] consent to others below it?" (Abramson et al., 2012, p. 362).

In some instances, it doesn't matter. A recent analysis of the UK Sexual Offences Act § 30 concludes that, in cases in which the victim has an intellectual disability, the law "takes in all potential sexual touching, from what would constitute rape to kissing and cuddling and everything in between" (Stanton-Ife, 2013, p. 206, in Baker and Horder, 2013). One of the coauthor's (MLP) experiences in New York have reflected wildly disjointed policies as to "what is sex" for the purposes of potential criminal prosecutions: In one county, he was told by a local assistant district attorney that penetrative patient–patient rape would most likely *not* be prosecuted because it was unlikely a jury would find a psychiatric patient (victim) to be credible; in another, he was told that if a patient touched another lightly on the shoulder in a friendly and warm way, that would be written up as an incident report "to protect us from liability." Neither approach makes any sense.

And how is homosexuality approached? As discussed in Chapter 3, one of the handful of early patients' rights cases that granted some right to "interaction," made clear that "patients shall be provided counseling or other treatment for homosexuality" (*Davis v. Watkins*, 1974, p. 1208). More recently, more enlightenment has been shown. In one case, a federal district court rejected—on due process grounds—a defendant's motion to dismiss a case challenging a state policy allowing for heterosexual expressions of intimacy in a state hospital (the same one, Napa State, that Sy wrote about 15 years ago) but threatening to punish homosexual expressions of intimacy (*O'Haire v. Napa State Hosp.*, 2009, 2010).

Consider other sexual issues as well. Recall the case of *Kortner v. Martise* (2014), discussed in Chapter 3, involving an unsuccessful civil suit that had alleged that the institution of a sadomasochistic sexual relationship had been undertaken when one party had been legally unable to consent to sexual conduct. (id., p. 445). There, the court was willing to countenance the possibility that a woman with mental disabilities could enter consensually and knowingly into a sadomasochistic sexual relationship with an individual who was *not* a person with mental disabilities (see Perlin and Cucolo, 2015, § 9-5.1 et seq.).

Also of significance is the question of the use of sex toys. The Eleventh Circuit Court of Appeals astoundingly upheld an Alabama statute banning the sale of sexual devices of the sort typically used by women (*Williams v. Att'y Gen. of Ala.*, 2004, p. 1250), a decision that "effectively criminalize or pathologizes all women who use sexual devices" (Chazan, 2009, p. 275), as well as causing unneeded or unwarranted shame and humiliation to them (Perlin and Weinstein, 2014). Significantly, for the purposes of this work, at least one of the plaintiffs who had unsuccessfully challenged the constitutionality of the Alabama law was a woman with chronic *physical* disabilities that made sexual intercourse extremely painful (Sproule, 2004), and making the use of the devices "a necessary part of her intimate relationships" (McKenna, 2011, p. 238).

Of great interest is that, while there is virtually no academic literature to be found on this topic (searching both legal databases and the more generic scholar.google.com), a simple Google search for "sexual device and disability" reveals an astonishing number of disability-focused websites discussing this issue (see, e.g., Ederyd, 2015, article titled, *This New Dildo Is a Form of Activism for People with Disabilities*); http://disabilityhorizons.com/2014/07/disability-and-sex-lets-be-frank-about-sex-toys/; http://www.intimaterider.com/sex-aid-for-the-disabled). But remarkably, this appears to have passed entirely under academics' radar screens.[1]

VIII. Conclusion

In short, there are multiple issues that must be considered when seeking to unpack the layers of bias, stigma, and pretext that infect this area of law and policy. Treatment providers should continue to be educated in the various forms and ways through which individuals with disabilities may choose to express or identify their sexuality and sexual desires. Additionally, providers and clinicians must continue to recognize the ways in which gender and sex are often interrelated, and work to ensure that each individual is given the chance to define his or her own identity despite the complicated gender politics of sexuality. We are confident that the issues we raise here are ones that will draw more attention in the coming years.

6

Therapeutic Jurisprudence

I. What Is Therapeutic Jurisprudence?

One of the most important legal theoretical developments of the past two decades has been the creation and dynamic growth of therapeutic jurisprudence (TJ) (Wexler, 1996; Winick, 2005; Wexler and Winick, 2003), a term first used by Professor David Wexler in 1987 (Wexler, 1992). Initially employed in cases involving individuals with mental disabilities, but subsequently expanded far beyond that narrow area, therapeutic jurisprudence presents a new model for assessing the impact of case law and legislation, recognizing that, as a therapeutic agent, the law that can have therapeutic or antitherapeutic consequences (Perlin, 2009c; Diesfeld and Freckelton, 2006). The ultimate aim of therapeutic jurisprudence is to determine whether legal rules, procedures, and lawyer roles can or should be reshaped to enhance their therapeutic potential while not subordinating due process principles (Perlin, 2003e; Perlin, 2005a). There is an inherent tension in this inquiry, but David Wexler clearly identifies how it must be resolved: "The law's use of mental health information to improve therapeutic functioning [cannot] impinge upon justice concerns" (Wexler, 1993, p. 21; see also, Wexler, 1996). As the coauthors have written elsewhere, "An inquiry into therapeutic outcomes does not mean that therapeutic concerns 'trump' civil rights and civil liberties" (Perlin and Lynch, 2014, p. 278; see also, Perlin, 2000a, p. 412; Perlin, 1998b, p. 782).

Therapeutic jurisprudence "asks us to look at law as it actually impacts people's lives" (Winick, 2009, p. 535) and focuses on the law's influence on emotional life and psychological well-being (Wexler, 2000). It suggests that "law should value psychological health, should strive to avoid imposing anti-therapeutic consequences whenever possible, and when consistent with other values served by law should attempt to bring about healing and wellness" (Winick, 2003, p. 26). TJ understands that, in the context of criminal cases, "when attorneys fail to acknowledge their clients' negative emotional reactions to the judicial process, the clients are inclined to regard the lawyer as indifferent and a part of a criminal system bent on punishment" (Cruz, 2010, p. 59). By way of example, therapeutic jurisprudence "aims to offer social science evidence that limits the use of the incompetency label by narrowly defining its use and minimizing its psychological and social disadvantage" (Steinberger, 2003, p. 65).

In recent years, scholars have considered a vast range of topics through a therapeutic jurisprudence lens, including, but not limited to, all aspects of mental disability law, domestic relations law, criminal law and procedure, employment law, gay rights law, and tort law (Perlin, 2002–3). As Ian Freckelton has noted, "It is a tool for gaining a new and distinctive perspective utilizing socio-psychological insights into the law and its applications" (2008, p. 582). It is also part of a growing comprehensive movement in the law toward establishing more humane and psychologically optimal ways of handling legal issues collaboratively, creatively, and respectfully (Daicoff, 2000). These alternative approaches optimize the psychological well-being of individuals, relationships, and communities dealing with a legal matter and acknowledge concerns beyond strict legal rights, duties, and obligations. In its aim to use the law to empower individuals, enhance rights, and promote well-being, therapeutic jurisprudence has been described as "a sea-change in ethical thinking about the role of law . . . a movement towards a more distinctly relational approach to the practice of law . . . which emphasises psychological wellness over adversarial triumphalism" (Brookbanks, 2001, pp. 329–30; see also, Winick, 2007; Winick and Wexler, 2006). That is, therapeutic jurisprudence supports an ethic of care (Winick and Wexler, 2006; Wexler, 2007).

One of the central principles of therapeutic jurisprudence is a commitment to dignity (Winick, 2005). Ronner describes the "three Vs": voice, validation, and voluntariness (Ronner, 2008, p. 627), arguing:

> What "the three Vs" commend is pretty basic: litigants must have a sense of voice or a chance to tell their story to a decision maker. If that litigant feels that the tribunal has genuinely listened to, heard, and taken seriously the litigant's story, the litigant feels a sense of validation. When litigants emerge from a legal proceeding with a sense of voice and validation, they are more at peace with the outcome. Voice and validation create a sense of voluntary participation, one in which the litigant experiences the proceeding as less coercive. Specifically, the feeling on the part of litigants that they voluntarily partook in the very process that engendered the end result or the very judicial pronunciation that affects their own lives can initiate healing and bring about improved behavior in the future. In general, human beings prosper

> when they feel that they are making, or at least participating in, their own decisions. (Ronner, 2002, pp. 94–95; see, generally, Ronner, 2010)

The question before us is this: Does the way that we regulate the sexual lives of persons with mental disabilities (especially those who are institutionalized) promote a vision that is consonant with the principles that Professor Ronner sketches out in this paragraph (see, e.g., Wexler, 2012; Perlin and Lynch, 2014)? Taking as a given the accuracy and importance of Professor Ronner's "three Vs," it follows that an individual must feel that those who regulate her life has genuinely listened to, heard, and taken seriously her story and her wishes. In the context of this book, a fourth important "V" might be "visibility": Is the person with disabilities being treated as if she were *invisible* (see, e.g., Winick, 1999, p. 58, discussing the structure of involuntary civil commitment hearings). To what extent has the way we treat questions of the sexuality of persons with disability absorbed and incorporated TJ values?

II. The Significance of Dignity

We have sought to answer the question above in this book. Before we use the TJ filter to reconsider the issues that we have already discussed, it is necessary to focus more closely on TJ's commitment to *dignity* (Winick, 2005). Writing about this question recently, the coauthors stressed: "Dignity concerns and rights violations will occur if there is not a full understanding of the importance of the ability for persons with mental illness to practice free sexual expression" (Perlin and Lynch, 2014, p. 261). Does the current state of affairs reflect this "full understanding"? To answer this meaningfully, it is first necessary to more fully deconstruct the meaning of *dignity* in the legal process (see, generally, Perlin, 2013e).

Professor Carol Sanger suggests that dignity means that people "possess an intrinsic worth that should be recognized and respected" and that they should not be subjected to treatment by the state that is inconsistent with their intrinsic worth (Sanger, 2009, p. 415). Treating people with dignity and respect makes them more likely to view procedures as fair and the motives behind law enforcement's actions as well-meaning (Birckhead, 2009). What individuals want most "is a process that allows them to participate, seeks to merit their trust, and treats them with dignity and respect" (Munford, 2007, p. 393).

The legal process upholds human dignity by allowing persons subject to legal regulation to tell their own story (Kruse, 2008, p. 1353, discussing Luban, 2007, pp. 68–72). In the context of the criminal justice system, the notion of individual dignity, "generally articulated through concepts of autonomy, respect, equality, and freedom from undue government interference, was at the heart of a jurisprudential and moral outlook that resulted in the reform, not only of criminal procedure, but of the various institutions more or less directly linked with the criminal justice system, including juvenile courts, prisons, and mental institutions" (Miller, 2004, p. 1569, n. 473). Certainly, these principles should apply equally in the context of the treatment of institutionalized *civil* patients.

The right to dignity is memorialized in many state constitutions (see Castiglione, 2008), in multiple international human rights documents (Perlin, 2011b, pp. 37–41; Birgden and Perlin, 2009; Perlin and Dlugacz, 2009), in judicial opinions (see Rao, 2008; Daly, 2011), and in the constitutions of other nations (Chaskalson, 2011). "At the institutional level, the legal process upholds a criminal defendant's human dignity by allowing him to remain silent—to put the state to its proof of guilt beyond a reasonable doubt—and to argue any inferences that are consistent with innocence, even if the defendant (and his lawyer) know that these inferences are in fact false" (Kruse, 2008, pp. 1353–54, discussing Luban, 2007, pp. 72–73). Dignity requires that all individuals be given an opportunity to participate in a political and social community supported by the state (Rao, 2008, pp. 219–20). In its recent decision upholding the right to gay marriage, a majority of the Supreme Court noted pointedly, "There is dignity in the bond between two men or two women who seek to marry and in their autonomy to make such profound choices," (*Obergefell,* 2015, p. 2599), and concluded:

> [Petitioners'] hope is not to be condemned to live in loneliness, excluded from one of civilization's oldest institutions. They ask for equal dignity in the eyes of the law. The Constitution grants them that right. (Id., p. 2608)

Both governmental entities and mental health professionals are tasked with the provision of dignity. By way of example, psychologists are to demonstrate respect for individuals by acknowledging their legal rights and moral rights, their dignity, and their right to participate in decisions affecting their lives (see Australian Psychological Society, 2007; see also Birgden and Perlin, 2009, pp. 59–88, listing principles of respect for dignity, competent caring for individuals' well-being, integrity of mental health professionals participating in forensic systems, and demonstrating professional and scientific responsibilities to the larger community).

We have discussed the relationship between international human rights law and questions of institutional sexuality, especially in the context of the United Nations' Convention on the Rights of Persons with Disabilities

(CRPD) (see Chapter 3). Dignity is the first "fundamental axiom" upon which the Convention is premised (Lang, 2009, p. 273), and it is inextricably linked to the concept of "human worth" (Ploch, 2012, pp. 895–96). As noted previously, the CRPD calls for "respect for inherent dignity" (CRPD, Article 3[a]). The Preamble characterizes "discrimination against any person on the basis of disability [as] a violation of the inherent dignity and worth of the human person" (CRPD, Preamble (h)). These provisions are consistent with the entire Convention's "rights-based approach focusing on individual dignity" (Dhir, 2005, p. 195), placing the responsibility on the state "to tackle socially created obstacles in order to ensure full respect for the dignity and equal rights of all persons" (Quinn and Degener, 2002, p. 14; see also, Vischer, 2011). Per Professor Cees Maris: "The Convention's object is to ensure disabled persons enjoy all human rights with dignity" (Maris, 2010, p. 1156).

Each section of the CRPD empowers persons with mental disabilities, and one of the major aims of TJ is explicitly the empowerment of those whose lives are regulated by the legal system (Perlin, 2011b, p. 21). The CRPD is, in many ways, a TJ blueprint. It privileges autonomy, promotes dignity, and values psychological health. If TJ encourages the law to "enhance [its] therapeutic potential" (Perlin, 2005a, p. 751), enforcement of the CRPD serves that enforcement role in the way that persons with mental disabilities are treated with regard to their sexual being. If a TJ perspective is adopted, that will also be the best way to ensure that the sanism (see Chapter 2) that pervades how the law treats persons with mental disabilities on questions of sexuality and sexual expression is rooted out of the system (see Perlin and Lynch, 2015b); as one of the coauthors (MLP) has written previously, TJ "might be a redemptive tool in efforts to combat sanism, as a means of 'strip[ping] bare' the law's sanist façade'" (Perlin, 2008a, p. 591).

III. Will Professor Ronner's Vision Be Fulfilled?

Given the way we deny the sexuality rights of persons with disabilities, is it remotely possible that Professor Ronner's vision—of voice, voluntariness, and validation—will be fulfilled? In a thoughtful analysis of the underlying issues, Professors Julie Tennille and Eric Wright have listed multiple benefits of a "communicative climate" for consumers with regard to sexuality issues: "[h]ealthy sexual relationships can foster development and maintenance of new relationships, a key element in social integration; positive sexual partnerships can increase quality of life, and those with mental health conditions who maintain relationships often have better treatment outcomes; some research indicates that hospital readmission rates dropped if consumers were able to develop romantic relationships; and stigma of mental illness may be reduced" (2013, pp. 13–14). Janine Benedet and Isabel Grant have also used a therapeutic jurisprudential filter in weighing these issues, and they have considered how to define "capacity to consent" and "engage in sexual activities" and how to ensure that such definitions remain person-centered and allow for a "situational approach" to each case (2013) They write: "Incapacity can and should be defined situationally—in a functional manner that maximizes [a person's] sexual self-determination" (id., p. 450). However, Benedet and Grant's thoughtful analysis and emphasis on the individual and his or her self-determination—two concepts linked with dignity—have not been greatly expanded upon in case law or legislation so as to give life to the therapeutic jurisprudential lens that they employ to view these issues of sexuality.

Another example of the way that TJ values can be introduced in this context comes from Australian law. In that nation's laws about the meaning of consent, Australian lawmakers clarified that the importance of consent was "to uphold the fundamental right of every person to make decisions about his or her sexual behaviour and to choose not to engage in sexual activity" (Victoria Crimes Amendment [Sexual Offences and Other Matters] Act, 2015, § 37A(a)). This is incredibly resonant with TJ, as it provides an outlet for voice, validation, and, in particular, voluntariness of action. A law such as this, influenced by TJ values, will only serve to promote the critical concept of voluntariness, both in the context of sexual consent and in the context of giving individuals with disabilities the opportunity to make decisions about their actions (see Bucci, 2015).

We must also question the therapeutic or antitherapeutic implications of official hospital policies that control the place, manner, and frequency with which such individuals can have sexual interactions. Recall our story in the introductory chapter about Debbie Dorfman's colloquy with the facility manager who sought to limit his residents' times of sexual interaction to the times that he and wife had sex. We must consider the implications of these policies on ward life and their implications for patients' posthospital lives. These questions are difficult ones, but we must ask them nonetheless if we wish to formulate a thoughtful, comprehensive response to the wide range of questions this subject raises (see Perlin, 1993–94, p. 547). Importantly, a recent study of patients and sexuality at a forensic hospital in Victoria, Australia, underscored how consumers believed that sexual autonomy was therapeutic to them. Note the authors:

> Consumer participants also shared the view that a close, intimate relationship and the feeling of being loved are therapeutic and an aspect of their lives that supports their personal recovery:

> I reckon it'd be very therapeutic. The sense of feeling loved by another person can help you progress quicker, and supporting each other through stuff that nurses can't help you with. It helps you with certain emotions, like if you are a male and you're a bit aggressive, it can help you mellow out . . . having a relationship with a female. (Andrea)

The deep connection of being with someone, and the supportive part of a relationship, was acknowledged by consumers:

> It's one thing going out with someone, and another to go out and have sex with them. It's completely different. It's more intimate; it's completely different to holding hands, going out for coffee and kissing and that. Having sex with someone, you get to know them on a deeper level. (Ethan) (Quinn and Happell, 2015a, p. 125)

Law professors who teach about mental disability law must take these issues seriously. One of the coauthors (MLP) has, for over 20 years, taught about sexuality rights in his Survey of Mental Disability Law course, and in his Therapeutic Jurisprudence course. He does this because he believes it is essential that students confront these difficult questions of autonomy and social justice if they are to truly understand the deep textures of what they are studying. And he believes that the application of TJ values best illuminates the issues at hand. There is resistance on the part of many students (just as there is resistance on the part of faculty). But we will continue to articulate these views and to call out those whose sanism blinds them to the issues at hand (see Perlin and Lynch, 2015a).

The other coauthor (AJL) was introduced to these topics through a course on therapeutic jurisprudence. Sexual autonomy was only one of the myriad issues brought to the attention of students who had never considered that they harbored unconscious biases against individuals with mental disabilities. Over the course of the semester, and through AJL's continued studies in TJ and mental disability, it became clear that TJ provides a mechanism for implementing social change, especially in areas like sexuality that are so riddled with stigma, bias, and fear. Using TJ as a tool for change not only affects the individuals with mental disabilities who are so scrutinized for their behavior, but it also can be a powerful teaching tool and motivator for law students to engage in critical advocacy and policy work for marginalized populations. Taught appropriately, TJ can encourage a new generation of public interest attorneys who will be armed with more knowledge, insight, and understanding for the marginalized populations they set out to serve (Perlin and Lynch, 2015a).

So what are some of the conclusions that we have come to? All of the issues that we have discussed in this book must be considered through multiple filters: through the filter of sanism, through the filter of international human rights, and through the filter of domestic antidiscrimination law (Perlin and Lynch, 2014, p. 299). Each of these considerations must be contextualized with society's attitudes toward sexuality in general, and, specifically, the bundle of attitudes that comes into play when we think of sexuality and persons with disabilities, and *especially* when that sexuality is not simply "vanilla" male–female intercourse. Our prejudices, our fears—both spoken and unspoken—dominate the discourse (or, often, the lack of discourse) in this area of law and policy, and it is essential that we confront this as we approach these issues (id., pp. 299–300). The substantive topics and the detrimental laws that do exist remain so under-discussed because we are still so astonishingly uncomfortable thinking about the questions at hand. We want to close our eyes to the reality that persons with mental disabilities are sexual beings, and we want to close our eyes even more to the fact that their sexuality may be much more like "ours" than it is different. And, our current policies fly totally in the face of the "three V's" that Professor Amy Ronner articulated as the heart of therapeutic jurisprudence: voice, validation, and voluntariness. They also are inconsistent with international human rights conventions and perpetuate sanism.

IV. A Consideration of All Topics from a TJ Perspective

Think carefully of the range of topics covered in this book, and assess them all from a TJ perspective. There are a handful of constitutional law cases and consent orders that appear to give patients some sexual autonomy rights, but they are rarely enforced or expanded upon. The Americans with Disabilities Act has been the law for over 15 years, but it is has virtually never been utilized by advocates as a tool of social change in this area of law and policy. We know that pretextuality is to blame for the reality that the law on the books is often little more than an illusion; "successful" cases brought on behalf of persons with mental disabilities are often little more than "paper victories" (Perlin, 2002, p. 429). The use of therapeutic jurisprudence—again, to expose pretextuality and strip bare the law's sanist façade—has the potential to become a powerful tool to serve as "a means of attacking and uprooting 'the we/they distinction that has traditionally plagued and stigmatized [persons with mental disabilities]'—then that result will be therapeutic: for the legal system, for the development of mental disability law, and ultimately, for all of us" (Perlin, 2000d, p. 301).

Consider now questions of competency. We have stressed that there is no unitary definition of competency in this area. Often, there are no definitions, and when definitions exist, they are often circular and contradictory. Second, there is a whole range of issues to be considered in determining "sexual competency," but, as the cases we have discussed should make clear, these factors change from case to case, jurisdiction to jurisdiction, and substantive topic to substantive topic. However, where policies exist, they are often stigmatizing and marginalizing and do not allow for the range of opportunities to engage in sexual activities afforded to those without mental disabilities. Competency is multitextured and must be evaluated in multiple fact-settings—involving a plethora of issues, ranging from the impact of dementia on competency to consent to sex, to the application of "statutory rape" laws to consensual sex between persons with disabilities, to the competency of persons with disabilities to testify in court proceedings, to consent to sexual risk, to fitness to marry, and to a range of other sexual "activities" and "situations," all discussed below.

Recall some of the examples discussed earlier in this book as to how staff makes informal decisions about whether patients should have relationships with other patients or how male and female patients are treated radically differently on issues of access to birth ontrol. In cases such as those, these implicit competency determinations fail to meet, by every metric, the rationales of therapeutic jurisprudence. Consider the question of the competency of a person with an intellectual disability to testify in a sexual assault case stemming from an incident in which she or he was victimized. Professors Janine Benedet and Isabel Grant have listed a series of recommendations for the trials of such cases—the use of support persons, the possibility that testimony might be given out of the courtroom or behind a screen, the use of video recordings, the use of "intermediaries" for witnesses with mental disabilities, and giving judges the explicit authority to intervene to support witnesses (2012, pp. 27–43). Although the words "therapeutic jurisprudence" are not mentioned in the article, it is clearly an exemplar of creative TJ thinking at its best.

Over 15 years ago, one of the coauthors (MLP) noted the explosion of TJ inquiries in areas of competency law, including competency to consent to treatment, competency to seek voluntary treatment, and competency to be executed (Perlin, 1997a, p. 982; see also, Perlin and Dorfman, 1996, considering competence of counsel in right to refuse treatment cases from a TJ perspective; Perlin, 1993, considering competency to stand trial from a TJ perspective; Perlin, 1996, considering competency of counsel in death penalty cases). The coauthors of this book have previously considered the relationship between competency and sexual autonomy in matters involving marriage, sterilization, and the criminal law (Perlin and Lynch, 2014). But other than literature applying TJ to *sex offender* cases (e.g., Schopp, 1995; Stephani, 2000) and the articles by Benedet and Grant and Tennille cited above, there have been no other investigations of the competency/TJ/sexuality overlap other than articles written by this book's coauthors (see Perlin and Lynch, 2014, 2015b).

Consider the discussions in this book of topics such as sterilization, the special circumstances of forensic facilities, medication side effects, sex education, institutional placements, institutional conditions, and reproductive technologies and rights. In each instance, an evaluation of our findings in the context of Professor Ronner's TJ prescriptions would show that our policies fail miserably (a finding that should not surprise us terribly, given the legal system's long-standing and well-documented woeful track record of comporting with therapeutic jurisprudence in many of these areas (see, e.g., Perlin and Dorfman, 1996, right to refuse medication; Perlin and Lynch, 2014, sterilization; Brody and McMillin, 2001, pregnancy issues; Perlin and Lynch, 2015c, institutional placement; Cohen and Dvoskin, 1993, institutional conditions; Perlin, 2008b, forensic facilities); Perlin and Lynch, 2015c (same).

We fail abjectly and miserably to comport with international human rights (IHR). The late Professor Bruce Winick taught us over a decade ago that "therapeutic jurisprudence principles can point the way to law reform" in all matters of international human rights law (2002, p. 544). Writing more recently, one of the coauthors (MLP) stressed that "it is essential that scholars begin to take seriously the relationship between TJ and IHR" (Perlin, 2014, p. 539). The coauthors have written about how, in considering questions of sexuality, "the use of the TJ filter—in the context of the articulated principles of international human rights law—offers us a means of approaching these questions in a new and, potentially, socially redemptive way, and in a way that, optimally, erases sanist attitudes" (Perlin and Lynch, 2015b, pp. 47–48). It is essential that litigators and other scholars consider this approach.

Often lost in discussions of constitutional theory and human rights proscriptions/prescriptions are the "nuts and bolts" of administrative law decision making. Although there are a handful of articles that deal with this issue in a TJ context in general (or about topics such as workers' compensation tribunals, see Wexler, 2012, for a short bibliography), there has been virtually nothing written about the extent to which hospital policies (whether formalized in "hospital policy" or simply informal "that's the way we do it here" directives) about patient sexuality comply with therapeutic jurisprudence principles (compare Mossman et al., 1997). This topic calls out for far more consideration.

And these observations have not yet gotten to the roots of the dilemmas we face: our *attitudes* toward the sexual autonomy of persons with mental disabilities, especially those who are institutionalized. Scholars have discussed the TJ implications of sanist bias toward persons with mental illness in such areas as the law of trusts and wills (e.g., Champine, 2003), of sex offender recidivism (Cucolo and Perlin, 2012), of clinical law teaching (Baker, 2006; Perlin, 2003e), of antidiscrimination legislation (Swanson et al., 2006), of comparative law perspectives (Perlman, 2008), of outpatient commitment laws (Cornwell and Deeney, 2003), and in other areas as well. But so much of the attitudinal material that we have discussed in this book—the weight of historical attitudes (Marino, 2014), the continuing power of religiosity (Kulick and Rydstrom, 2015; Tannahill, 1992), how we view sexualization and desexualization (e.g., McCann, 2000; Wouters, 2010), how we assess sexuality and sexual desire in older adults (Tenenbaum, 2009), attitudes of hospital staffs (Yool et al., 2003), medical professionals (O'Dea, Shuttleworth and Wedgwood, 2012), and patient advocates (McCann, 2000)—has never heretofore been considered from a TJ perspective. It is essential that we turn to these issues.

We must also examine questions dealing with specific disabilities—e.g., autism (Gilmour et al., 2012), spinal cord injuries (Pebdani et al., 2014), intellectual disabilities (Dimopolous, 2012); those dealing with specific facilities, beyond the already-noted forensic hospitals (e.g., prisons, Cusack, 2014b), nursing homes (Tenenbaum, 2009), congregate living facilities in the community (Alladina, 2011); and "other" populations (e.g., those who have been sexually abused, see Murphy et al., 2007). Again, there has been virtually no consideration of any of these matters.

Finally, we need to consider the issues that, we have found, make many/most of our colleagues the most uncomfortable: What do we mean by "sex" (e.g., Stanton-Ife, 2013)? How do our views on masturbation influence the remainder of our views on this topic (e.g., Gill, 2012)? What about the use of sex toys (compare Perlin and Weinstein, 2014), or access to sexually explicit literature or visual imagery (e.g., Appel, 2010)? What about "nonvanilla" sex, such as S&M practices (e.g., *Kortner v. Martise,* 2014), or what is popularly labeled "perverse sex" (e.g., Peakman, 2013)? What about polyamorous sex (Aviram and Leachman, 2014)? What about the ways that we typically conceptualize the need/desire for sex differently for men and for women (e.g., Brouwer et al., 1998; Bahner, 2012)? What about "facilitated sex" (e.g., Earle, 2001)? What about orgasm (e.g., Glass and Soni, 1999)? These are the hardest questions of all because they bring up topics that so many wish would just "go away" (see Perlin, 1993–94, p. 534).

When one of the coauthors (MLP) first addressed these issues over two decades ago, he asked:

> Is it clinically beneficial or antitherapeutic to allow institutionalized patients autonomy in sexual decision making? In answering this question, to what extent ought we consider research on the therapeutic value of touching and physical intimacy? (Perlin, 1993–94, p. 524, citing Montagu, 1971; Harlow et al., 1971)

But there is virtually no other mention in the law review literature on this value (compare Brunschwig, 2012, p. 737, discussing, in the context of an article about TJ and family mediation, why some spouses reject any exercise that involves touching their partner with whom they have a "conflict-laden relationship"). Only Professor Warren Brookbanks has considered the application of TJ to *intimacy*, arguing that TJ has "redefined the role of law as a means of problem-solving and offers an alternative approach to legal practice *based on a model which encourages relational intimacy*, self-awareness, conciliation and restoration" (2001, pp. 329–30; emphasis added). It is essential that we consider this insight in the context of the subject matter of this volume. If persons with mental disabilities—especially those institutionalized because of mental disability—are granted the same sexual autonomy that the rest of us have, that gives this population voice. If they are allowed voluntary sexual interaction, that, by definition, provides the sort of participatory experience that leads, in a TJ framework, to a sense of voluntariness, all thus fulfilling Professor Ronner's majestic vision and the aims set out by Professors Wexler and Winick over two decades ago. Together, these help increase the self-validation of those in question (Perlin and Lynch, 2015b).

As society in general becomes increasingly open and direct about sex and sexuality, "aided by the values of a consumer culture and encouraged by the growing visibility of sex in the public realm, many now regard sexual pleasure as a legitimate component of their lives" (id., pp. 46–47, quoting, in part, Goodwach, 2005, p. 157). This openness and directness must be allowed to extend to persons with disabilities if full equality for this population is to be achieved And we would be remiss if we did not acknowledge the reality that—given the reality that this substantive topic has always been "closeted"—talking about it openly is emancipatory to all involved in this enterprise.

Writing about this topic some time ago, one of the coauthors (MLP) said the following:

> In the past four decades, a sexual revolution changed the way we think about gender, sex roles, personal relationships, and sexual expression. The last thirty years have seen a legal civil-rights revolution affect the way that we think about persons with mental disabilities, both in institutional and community settings. The last twenty years have seen a revolution in the joining together of the international human-rights movement and the mental disability law movement. Perhaps we can now turn our attention to the relationship between these two revolutions. (Perlin, 2008b, pp. 511–12)

We still hold this sentiment as true today. Through advocacy, understanding, and implementation of principles consistent with TJ, this area of law and policy can continue in the wake of so many other successes for the rights of individuals with mental disabilities.

Notes

Chapter 1

1. Sanism is an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry. It infects both our jurisprudence and our lawyering practices; it is largely invisible and largely socially acceptable, based predominantly upon stereotype, myth, superstition, and deindividualization. See Perlin, 2008b, p. 481, and see, generally, Chapter 2.
2. Some, in fact, were not mentally ill at all but were individuals with physical disabilities who had been "dumped" at the institution within a week of being born and had been there ever since (Perlin, 2005b, p. 37).
3. At the time, MLP was director of the NJ Division of Mental Health Advocacy (DMHA). See, e.g., Perlin, 1982.
4. The NJ DMHA, which the coauthor directed, was a state-funded agency.
5. This presentation was ultimately expanded into Perlin, 1993–94.

Chapter 2

1. The phrase "sanism" was most likely coined by Dr. Morton Birnbaum. (Birnbaum, 1974, pp. 106–07), discussed in this context in Perlin, 1991a, pp. 92–93.
2. The ironic use of the word "whores" in this context is worthy of note.
3. It is important to stress that there is convincing evidence that increased contact with persons with mental illness is associated with lower stigma (Kolodziej and Johnson, 1996; Corrigan and Penn, 1999). "Members of the general public are more likely to diminish prejudicial attitudes and discriminating behaviors when they have contact with people with mental illness" (Corrigan and Matthews, 2003, p. 235).
4. "A man that is totally deprived of his understanding and memory, and doth not know what he is doing, no more than an infant, than a brute, or a wild beast, such a one is never the object of punishment" (*Rex v. Arnold*, 1724).

Chapter 3

1. Cook's article is cited approvingly in, inter alia, *Valentine v. American Home Shield Corp.*, 1996, p. 1388; *Muller v. Hotsy Corp.*, 1996, p. 1402 ; *Heather K. ex rel. Anita K. v. City of Mallard,* 1995, pp. 1263–64; *Breen v. Carlsbad Municipal Schools*, 2005, p. 421); *Muller v. Costello,* 1999, pp. 308–9.
2. This is consistent with case law interpreting the Rehabilitation Act of 1973, a predecessor to the ADA, that "sexual contact" is a major life activity under that act (*Doe v. District of Columbia,* 1992, pp. 559, 568).
3. It was believed, for centuries, that "immoral sexual behavior can cause insanity" (Halevy, 2015, p. 3, quoting McCandless, 1981, p. 354; see also, Sadler, 2013, p. 4: "In the early centuries of the monotheistic religions (Judaism, Christianity, Islam) madness was described both as a punishment for wrongdoing and possession by evil demonic entities," wrongdoing being defined explicitly to include "lust").
4. There are other issues of significance that lie just at the borders of this book—consensual incest, "sexting," bestiality. They will be discussed briefly at the end of this chapter.
5. For example, a sadomasochistic sexual encounter may appear to be a "struggle," rather than "traditional" sex in which both parties outwardly appear to enjoy the activity. However, there is still clear consent and safeguards, including a "safe word" to ensure that either party can stop the activity at any time. The sexual fulfillment is created by the appearance of these power dynamics during the encounter, but in no way distorts the fact that clear consent has been given (Cross and Matheson, 2006).
6. See Austin Lakes Hospital FAQs, http://austinlakeshospital.com/resources/faq/; see also the Mental Health Commission of Canada's discussion, "Patient Internet Access of Psychiatric Wards," http://www.mentalhealthcommission.ca/English/discussion/21531/patient-internet-access-psychiatric-wards.

Chapter 4

1. We should note that the discussion in this section is based on American law and, to some extent, American society. By way of contrast, scholars have reported that, in Taiwan, reproduction decisions involving persons with intellectual disabilities are considered to be a "familial issue involving the *man's* parents" (Werner, 2012, p. 17, quoting Ko and Muecke, 2005, emphasis added).
2. To be clear, many *nondisabled* public school students have parents who vigorously oppose sex education, mostly because of alleged religious reasons (Merriam, 2007).
3. Interestingly, much of the literature about the CRPD has focused upon persons with disabilities as the "world's largest minority," see Kayess and French, 2008, p. 4, n. 16, discussed in this context in Perlin 2013c, p. 1173, n. 62).

Chapter 5

1. There are other issues, of course, to consider in this context, beyond the scope of this book: autoeroticism (e.g., Schuman, 2014), sex during unconsciousness (e.g., Sealy-Harrington, 2014; Jochelson and Kramar, 2012), female genital mutilation (e.g., Avalos, 2015), non-consensual insemination (e.g., Cusack, 2014a), polyamory (e.g., Aviram and Leachman, 2014), and polygamy (e.g., Deutsch, 2014). We expect, however, that in future years, scholars (and perhaps advocates) will turn their attention to these issues as well in the specific context about which we write.

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