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Incorporating Sexual Surrogacy into The Ontario Direct Funding Program

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Abstract

Sexual surrogacy is an often overlooked and misunderstood concept in modern society where it is frequently seen as being a type of glorified prostitution. In fact, sexual surrogacy functions as a real and meaningful form of erotic communication and self-realization and is practised widely in the United States. People with disabilities in the Canadian province of Ontario who may not have access to sexual partners and who are seeking greater personal fulfillment should have the cost of sexual surrogates incorporated into their government-sponsored personalized funding program in order to access this critical aspect of disability rehabilitation whose fundamental objective is the achievement of sexual self-esteem.

The struggle for social equality for people with disabilities is relatively new. While other minority groups such as People of Colour, Jews, Muslims and Gays and Lesbians have all succeeded to a significant degree in securing legislation in Ontario (most notably through the Ontario Human Rights Code) which protects and defends their inalienable right to be equal citizens of the province, people with disabilities continue to struggle with culturally sanctioned ableism which challenges their right to be equal citizens of society, entitled to the same expectation of dignity by others.

Despite the hopeful promise of the proposed Ontarians With Disabilities Act legislation, Ontarians with disabilities themselves are still actively involved in vindicating their rights not merely as a segment of the chronic care population, but as a legitimate and recognized cultural minority within Ontario whose rights to a secure, happy and hopeful future should be within their reach as easily as it may be for other minority groups in the province. Inherent to the international disability rights movement is the objective of people with

disabilities to be seen as other members of society who share similar social needs and expectations and who are recognized as complex human beings entitled to the same rights and social functioning as other minority groups. Fundamental to such social complexity, is the reality of human sexuality and the right of every human being to be recognized as a sexual being and to be able to express their sexuality in the context of their sexual orientation in appropriate ways in an attempt not only to enjoy sexual gratification, but also to manifest their identity as a sexual being and to claim their right as an equal member of society regardless of their age, gender, race, religion, sexual orientation or ability.

For many Ontarians with Disabilities, opportunities to locate partners and express their sexuality are limited. Though people with disabilities are more independent and integrated in society than they ever were before, many still feel the misperception of people with disabilities as being asexual and poorly socialized. Medical practitioners rarely discuss sexual issues with their patients who have a disability. Often rehabilitation specialists avoid issues of sexuality for fear of embarrassing their client.

While concerns about sex and sexuality are raised in certain contexts, the opportunity to be sexual and reclaim their bodies is often not a possibility for many Persons With Disabilities. This is particularly unfortunate for people with disabilities who may have been single prior to acquiring their disability and perhaps were not sexual at an earlier time in their life. Sexuality is a complex and highly misunderstood concept in our society where so many people equate sexuality with intercourse itself and cannot appreciate the important learning experience of being sexual and how being sexual transcends sexual behavior per se and often can be part of an enormously larger healing process.

It is the intent of this position paper to espouse the idea of sexual services for people with disabilities in Ontario by examining the role of sexual surrogates as a therapeutic mechanism in the on-going rehabilitation of Persons With Disabilities and to suggest the Ontario Ministry of Health incorporate sexual surrogacy into its Direct Funding Program and thus allow Centres for Independent Living to assist people with disabilities in Ontario to access sexual surrogates as a type of assistive care in conjunction with the government-sanctioned attendant care they may be already be receiving.

Starting as a pilot project in 1994 and becoming a permanent program in 1998, The Direct Funding Program which is funded by the Ontario Ministry of Health and administered through the Centre for Independent Living in Toronto, follows the philosophy of the Independent Living Movement which espouses the idea that persons with disabilities should have the right to control their own lives and not be ghettoized or made invisible by society. In order to maximize disability independence, The Direct Funding Program allows people with physical disabilities to manage their own attendant care

through a pre-arranged agreement between themselves and their attendant care worker(s).

In the context of the Direct Funding Program, attendant care refers to individuals who assist the person with a disability in the physical assistance of performing everyday duties they would normally be able to perform if not for their disability. Such assistance would likely include transferring, showering, dressing and undressing. The Direct Funding Program allows the person with a disability to hire or fire the attendant worker who is brought to the attention of the person with a disability through their independent living center which provides funding to the individual. The person with a disability thus becomes an equal partner in the attendant care as it is they who assume responsibility for the arrangement and the management of the payment to the attendant worker. The Direct Funding program is therefore a "self-management" program for the person with a disability allowing them greater control over the quality of their care and at the same time requiring them to be responsible in the disbursement of funding and additional administrative responsibilities.

The Direct Funding program is restricted to those 16 years of age or over who are residents of the province of Ontario and require attendant care due to a permanent physical disability. It requires the individual to meet with a selection panel to discuss their needs and to ensure the individual is responsible and can meet the on-going requirements of the program. The Direct Funding Program is restricted to an understood set of requirements and duties of the attendant. At this time the attendant is not responsible for providing sexual services to the people they help nor are they required or expected to engage in any kind of therapeutic intervention as would be provided by, for example, a physiotherapist.

Attendants are not required to discuss sexual issues with their employers. ("Employers" in this discussion refers to the person with a disability who hires the attendant. It is the principle of the Direct Funding Program that the person with a disability is in fact employing the attendant with funds provided). Attendants are not expected to provide sexual gratification nor are they necessarily expected to purchase pornographic or adult material for their employers. The average number of hours per day the attendant will serve is normally six which in the context of the other duties they are required to perform would make it difficult to incorporate sexual services in their list of duties. Neither The Abilities Foundation nor the Canadian Association of Independent Living Centres has any policy on the use and/or benefit of sexual surrogacy for people with disabilities. At the present time, Canadian law remains ambiguous on this issue while at the same time certain American states have legalized sexual surrogacy recognizing it as a therapeutic benefit to the patient.

There currently exists no broad-based disability rights organization in Canada that has made any public statements concerning the sexual rights of Canadians with disabilities.

It would be most unfortunate if, based on such social irresponsibility, the public assumed that people with disabilities do not seek therapeutic sexual services simply because their presumed spokespeople do not engage the media in this most relevant and worthwhile aspect of disability rehabilitation.

In summary, there does not exist at the present time any type of organized sexual services offered to people with disabilities within the province of Ontario. Nor does there exist any effort by disability rights organizations on a national or provincial level to secure the sexual rights of people with disabilities within a health care framework. It would appear an organized effort on this issue is lacking, but such a judgement would neglect the reality which is that thousands of people with disabilities living in Ontario are sexual beings and thus have the right to manifest that identity in ways they see fit. The reality is that persons with disabilities seek sexual gratification, body awareness, greater personal bonding with others and the opportunity to understand their bodies on both a physical and erotic level. Present health care policy in Ontario does not recognize this and therefore this very real need must be addressed.

New Thinking and Approaches - What Sexual Surrogacy Is and What It Is Not

In order to meaningfully understand the dynamics of sexual surrogacy and its lasting social implications it is imperative to have a clear comprehension about the issue before us. Simply put, sexual surrogacy is not prostitution nor is it simply gratification in its most vulgar meaning. Sexual surrogacy is a therapeutic process which attempts to have the patient begin a dialogue with their own body in an attempt to, in a meaningful way, transcend simple gratification.

Research in this area has found a remarkable disparity between what sexual surrogates actually do and how the public perceives them. The most common activity performed by a surrogate was not sexual intercourse, but actually simple touching. The second most common activity recorded was not sexual intercourse either, but rather simply talking to the patient and giving reassurance and support. While sexual intercourse and oral sex exist as part of a sexual surrogate's repertoire, it does not represent the essence of the surrogate. In the context of disability we are not focused exclusively on gratification either. It is the concept of sexual self-esteem that is at the heart of this type of therapy.

What do we mean by sexual self-esteem? Clinically speaking, sexual self-esteem refers to "a positive regard for and confidence in an individual's capacity to experience his/her sexuality in a satisfying and enjoyable way." Sexual self-esteem therefore relates to how we see ourselves as facilitators of our own sexual gratification, but at the same

time it must imply the ability to accept one's own body as both attractive, whole and sexually relevant. Clearly the impact of disability on sexual functioning can have a significant effect on a person's sexual self-esteem.

In spinal cord related injuries, the ability to maintain an erection, experience orgasm or even to have children can impact the sexual self-esteem of the disabled person. Common concerns like "Will I still be able to have sex?" "Who would want to have sex with me?" and "Will I be able to satisfy my partner?" are all frequent questions heard by sex therapists who work with people with disabilities. What is important is to recognize that sexual self-esteem is a critical aspect to the patient's lifetime of rehabilitation both physically and emotionally. When we feel good about ourselves we simply do better whether it is professionally or personally. When we feel good about our bodies, when we can recognize and appreciate our own sexuality beyond the perceived impairment the disability may have caused, when we can see that sexuality exists beyond intercourse and immediate gratification, then we develop a healthy sexual self-esteem and then are able to place disability into a compartment which does not overwhelm our lives. This is not to minimize the significant challenges people with disabilities face, but it is the foundation of disability theory that it is society's perception of people with disabilities that can often be their greatest impediment. Often such attitudes include the myth that people with disabilities are asexual or that they are all heterosexual. Such attitudes limit the social development of people with disabilities.

Then what exactly are the type of services a sexual surrogate would provide to a person with a disability? Interviews conducted with sex workers in Toronto for the purpose of this research have illuminated a number of activities which are consistent with the research which lists intercourse as having a minimal presence in the type of sexual services normally provided to the patient.

A female bisexual sex worker who works with lesbian women, gay men and heterosexual couples begins her services by simply talking to the patient, getting to know them, understanding their anxieties, setting boundaries about the therapy and most importantly creating a sense of trust in the relationship to ensure maximum therapeutic value in the services provided. Breathing exercises are often incorporated as well. Physical interaction with the patient normally begins with what has been referred to as "sexually related therapeutic touch" in which the surrogate gently massages the patient with massage oil and engages in gentle strokes all over the patient's body while soothing music is played.

Within the therapeutic encounter, more explicit sexual practices have a meaningful and useful role to play in the session. Usually after fifteen minutes once the session has begun, the surrogate may focus on the client's desire to achieve multiple orgasm or to delay orgasm in order to reach a greater level of climax through back stimulation in

conjunction with explicit genital play through the use of the surrogate's hands. Avoiding intercourse by focusing on genital play in the context of the client's expressed desire for orgasm and/or multiple orgasm, this technique has often resulted in gratification by the client and is a useful way in achieving both orgasm and sexual self-esteem. There is often no agenda around genital stimulation within sexual surrogacy.

Another highly effective technique is simply talking to the client about what works for them. This technique may be attempted at the beginning of the session and while may seem innocuous, can often lead to significant arousal by simply letting the client verbalize their desires to their surrogate. Fundamentally speaking, the greatest single physical interaction attempted by the surrogate is the experience of receiving touch as it is manifested at different points in the session. Recalling that the client had rarely received touch since acquiring their disability, the experience of receiving touch becomes highly eroticized in this context. In both the pursuit of arousal and multiple orgasm, these sexual techniques become highly valuable to the surrogate at key moments in the session

The goal throughout is not exclusively to achieve orgasm in the patient nor is it to provide genital stimulation per se. The ultimate benefit of this type of therapy is to increase the sexual self-esteem of the disabled person through the physical pleasure of non-penetrative bodily contact and to help the disabled person learn about their own body. Often patients are so overwhelmed by this kind of intimacy that they had rarely experienced since their injury, that they are often brought to tears and a greater sense of letting go about themselves. The release of erotic energy and the opportunity to experience their sexuality became a huge therapeutic benefit to the patient. They have transcended societal perceptions of disabled people as being asexual and they have recognized their own innate sexuality and sexual self-esteem.

Recommendations

It is therefore recommended that sexual surrogacy be incorporated into the Ontario Direct Funding Program whereby a list of sexual surrogates will be made available to Independent Living Centres and that clients seeking sexual services will be able to access sexual surrogates through these centers and pay surrogates out of the funding currently provided to them through the Direct Funding Program. Most sessions with sexual surrogates may be between forty-five minutes to an hour and half. Rates can be expected to be between one hundred and one hundred and fifty dollars. Because of the public misperceptions regarding sexual surrogacy, it is recommended that a sexual surrogacy pilot project be offered on a small scale dealing only with lesbian women with disabilities who seek a female sexual surrogate. Sex workers interviewed for this research have strong connections to the

feminist community and recognize the sexual diversity of the disability community.

In an effort to anticipate misperceptions of this type of work by a larger repressed health care authority structure, the use of female sexual surrogates to provide women with disabilities same-sex therapy is an effective and discreet way to begin to analyze the long term benefits of this type of service free of the oppressive and disability-ignorant health care system. Lesbian women are a minority certainly within the spinal cord injured community and deserve recognition of their place within the disability community and of their status as a sexual minority. Sexual surrogacy among lesbians would be more readily accepted than among heterosexual or gay male communities because the lesbian community itself has a lesser media visibility than these groups and has historically operated in a much more discreet and less overtly sexualized way.

In addition, it is the position of this author that since women with disabilities have been consistently undertreated by the rehabilitation industry which has traditionally placed disability in a male context, women with disabilities deserve every opportunity to access new social policy which is geared toward their empowerment. Lesbian organizations have historically gravitated toward the women's movement which has placed sexuality on a continuum of unjustified gender bias whereas the male gay community has often manifested itself through its overt and highly visible desire to secure sexual gratification. In any major urban area in North America, gay male bath houses consistently outnumber any such similar establishments for women if indeed such establishments for women exist at all. Such reality creates and reinforces a public perception that gay men are more sexually driven than lesbians though no literature currently exists to support that.

By capitalizing on this public misperception of overt homosexual conduct distinguished by gender, a test pilot sexual surrogacy project focusing on lesbians veers away from the misperception of this work as prostitution and in offering this social progress recognizes the historic mistreatment women with disabilities have received by the health care industry.

Summary

It is recommended that a sexual surrogacy test pilot project operating out of the Ontario Direct Funding Program be attempted for lesbian women with disabilities for the following reasons:

i) Sexuality is an inherent aspect of being human and the opportunity to express that sexuality is a right of all people.

ii) Done under controlled conditions in a therapeutic setting by a professional, sexual surrogacy can have a tremendous positive impact in developing the sexual self-

esteem of the person with a disability and broadening their perception of themselves beyond their disability.

iii) Women with disabilities are equal members of both the disabled community, the gay/lesbian community and the women's movement and thus deserve equal consideration regarding their needs to be sexual with other women.

There are many social and legal implications for this type of service to be funded by a provincial government. Admittedly, Canadian law is ambiguous on the issue of sexual surrogacy. However, it is the position of this author that state-sanctioned sexual conduct is found in many public places in Canadian society not the least of which can be found in the male homosexual community where it is common knowledge that gay men gather to have sex with each other in so called "bath houses". Such conduct would not be tolerated in a heterosexual context. Clearly, society has afforded a special consideration to the male gay community regarding their sexual conduct in the belief that gay men have been historically persecuted for their sexuality and thus denied opportunity to assemble in an organized way to celebrate that sexuality.

If such consideration is offered to gay men, such consideration should be offered to people with disabilities who too have been persecuted, stigmatized and ghettoized into systemic social invisibility and in the process have been denied their inalienable right to be sexual. Therefore, it is the position of this report that legal exemptions be offered to the Canadian Association of Independent Living Centres in their service of providing sexual surrogates to people with disabilities as this type of work has an undeniable therapeutic value. The sexual rights of people with disabilities should not suffer the same ignorance that the dominant able-bodied community has dictated to them regarding other aspects of their lives.

The financial implications of including sexual surrogacy into the Direct Funding Program are real, but not overwhelming. In the context of a test pilot program, initial funding for a six month period for perhaps fewer than a dozen women receiving sexual services possibly once or twice per month could represent costs of approximately twenty-five thousand dollars to begin with.

The same restrictions would apply to the sexual services as they would apply to other requirements of the Direct Funding Program, i.e., the individual must be at least 16 years of age, must have a physical disability, be responsible for additional administrative requirements and also be able to evaluate the quality of such services. A list of sexual surrogates would be available at the Centre For Independent Living. Surrogates would then provide services in the privacy of the homes of their employers. A list of sexual surrogates can be created through the Toronto Sex Worker's Network and through tantric massage therapists in the area as well as through local contacts such as the sex worker identified in this study.

The idea of sexual surrogacy may seem daring, but it is

not new. In the United States sexual surrogates work in a variety of settings and, depending on the state they are working in, their professional conduct is legal and well appreciated. The International Professional Surrogate Association in California has had much experience in working with people with disabilities and has had much success.

Sexual surrogacy is a legitimate and relevant professional service. Clearly it is time such services became available to people with disabilities in Canada as the therapeutic value of such services has been clearly identified through scholarly research. The Ontario Ministry of Health now has the opportunity to recognize the sexuality of people with disabilities by extending funding of the Direct Funding Program to include sexual surrogacy which as we have seen is actually not sexual in nature, but pertains more to identifying and developing the sexual self-esteem of disabled people thereby providing a real and meaningful therapeutic value to them.

A test pilot project directed exclusively to lesbian women with disabilities would divert the public's perception of this type of work as prostitution by removing it from a heterosexual context and placing it in a feminist context geared toward the sexual empowerment of disabled lesbians. It is the position of this report that after a trial six month period, employers will have greatly enjoyed and appreciated the service provided by these surrogates and would want this additional funding to be shared by other people with disabilities in the province.

I would like to close this position paper through the words of a man with cerebral palsy who had worked with a sexual surrogate and had conveyed his sense of happiness about the experience to his mother who commented that her son felt good about himself, that he wanted to do it again, that he felt a sense of wholeness. For her son, sexual surrogacy had become an integral and essential aspect of both his rehabilitation and his own self-respect as a person with a disability.

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