

**DISCOURSES OF DISABILITY AND SEXUALITY:
BARRIERS TO SEXUAL CITIZENSHIP**

by

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Abstract

This project brings together two areas of discussion that are often avoided or completely denied: disability and sexuality. This thesis will employ a disability studies framework to understand the barriers that prevent disabled people from being sexually active citizens. I begin my looking to the historical, political, and cultural construction of disabled people's sexuality as a problem. Next, I take a cross-cultural perspective. I provide a cultural history of disability and sexuality in 20th Century Denmark. Disability and disabled people's sexual practices were once medicalized and institutionalized in Denmark. With social reform, the discourse changed, seeing the fundamental relationship between disability and sexuality normalized. I contrast this experience with Canadian policy and legislation, that continues to deny individuals with disabilities their status as sexual citizens. By examining the Immigration Act of 1910 and the Sterilization Act of 1928, I argue that colonial biopower segregated and aimed to eradicate minority groups from its goal of a pure Canadian state. I suggest these practices influence present-day policy. I find this discourse present a guide to sexual education that has been produced by the Government of Ontario, for parents of adolescents with developmental disabilities. Here disability remains an object of fear, danger, and something best avoided. This project ends by arguing for a critical movement encompassing disabled Canadians and the support necessary to achieve sexual status. I conclude with some recommendations to affirm sexuality for all, in both policy and pedagogy to come.

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Chapter 1

Introduction

Over the last two decades, I have had exposure to various systemic barriers and policy that perpetuate deficit-based discourses of disability. In this view, disability is a state of lack, where something is missing. People miss futures, life milestones, and full participation in social life. Contrasting these discourses of disability with my own first-hand accounts, I often wondered *why* do we (policy, medicine, legislation, education, various media) continue to discuss disability as a problem in the twenty-first century? Why do we avoid the topic of disability and relationships? I am a mom of three young adults with autism and while raising my children, I never avoided the topics of puberty, sexuality, or relationships. However, I realized that this type of education was evaded or completely avoided within the institutions managing disability in Canada. This need not be so.

There seems to be various myths about disability and sexuality, that I would like to address here. First, there is a dominant attitudinal belief that individuals with disabilities are asexual. Various authors point out, due to historical and cultural practices, like eugenics, disabled people were framed as asexual and/or sexually deviant (Kulick and Rydström, 2015; Sanders, 2007; Shildrick, 2012). Institutional practices were created to extract disabled people from society, leading to the restrictions of their sexual conduct. These made environments have repressed the sexuality for individuals with disability and their sexual autonomy (Siebers, 2011). Currently, in the twenty-first century, there remains a discomfort in the discussion or recognition of people with disability being sexual. Throughout this project, we will explore the historical, political, and cultural underpinnings that have constructed this discourse to disability and sexuality.

Another myth important to draw upon, is disabled people need medical care, and social supports, and these do not include sexuality. If we (in popular culture, in medicine, within policy and legislation) address sexuality, it is in a way that protects disabled people from it. Instead, we produce materials to give to parents, caregivers, and support workers to be aware of inappropriate sexual behaviours, the statistic of being sexually victimized, and the assumption that sexuality will merely be explored by oneself. Throughout the coming chapters, I will demonstrate how through institutions and social policy, we historically and currently medicalize disability. In this sense, we do not allow there to be the possibility of individuals with disability to explore their sexuality nor assist the opportunity.

Finally, sexuality is a private matter, whereas disability studies should focus on public awareness of disability. As Tobin Siebers (2011) discusses disability and sexual citizenship, everyone should be advocating for this status to be recognized. Why? Siebers suggests, that while current able-bodied people will eventually become disabled at some point. Therefore, the battle that individuals with disabilities have to their sexual rights, should be in the hands of everyone (2011). The taken-for-granted attitudes and beliefs about sexuality should be of a public matter. A space in which the private matters of sex, become a public platform for recognition and change.

Although disability and sexuality are not new topics within sociological research, I felt that it was important to understand why disability and sexuality remains problems within Canadian policy and legislation. I believe it is crucial that when we consider our youth and adolescents with disabilities, we affirm their sexuality, regardless of their disability. It is, in my view, critical for individuals with disabilities to have the same opportunity to live a normal life as possible. This includes the possibilities of relationships, dating, and having intimate relations. Here I look to the discourses that prevent these discussions. I begin with theories of disability and sexuality, before moving on to the case studies of Denmark and Canada.

The purpose of this project was to better understand the roots of deficit-based discourses on disability and sexuality. Over the course of this thesis, I will demonstrate the historical roots that continue to perpetuate barriers and restrictions to individuals with disabilities and their sexual status. First, I look to numerous theories within disability studies, to better understand current conditioning of disability. Particularly, I look to work on disability discourse, the ways we speak about the truth of disability over time. Next, I turn attention to Denmark, and the discursive shift social policy in the twentieth century, up to the current day. This discourse began in medicalized model of disability, but now looks to affirm the sexual citizenship of disabled people through sexual advisor certification. Finally, I turn to Canada. Here I pay particular attention to colonial biopower and its impact on Canadian people with disabilities. As it will become clear, it is crucial to recognize, individuals with disabilities and their status of sexual citizenship. It is imperative to understand the historical medicalization of disability and its continuum within the relationship of disability and sexuality. Whereby, the goal of this thesis is to demonstrate the continued discourse of disability and sexuality within Canadian culture and policy.

The layout of the chapters to come is as follows. Chapter 2, “Disability Studies” explores several theoretical frameworks within disability studies, to better understand current discourses of disability and sexuality. First, I draw on the work of Robert McRuer who, through a crip theory approach, demonstrates the construction of disability and queerness, with roots in heteronormativity. Next, I turn attention to Alison Kafer, who demonstrates through a feminist, queer, crip theory lens, the heteronormative powers that have constructed disability as problematic. Following this, I examine the work of Tobin Siebers and the cultural underpinnings that have shaped the identity landscapes for individuals with disabilities. Next, while looking at disability studies as both theory and method, I turn attention to the work of Michel Foucault and the medicalization of the body and disability. Here, I will shift focus to Tanya Titchkosky and

Anne McGuire, who demonstrate the dangerous discourses within institutions. Finally, I will shift focus to the works of Diane Richardson and Michael Prince who illustrate current discourses within our policy environment. This will prepare us for the work to come on disability politics in Denmark and Canada.

Chapter 3, “Denmark and Sexual Politics”, examines the history of disability and sexuality within Danish culture, institutions, and legislative policy. First, I will introduce the initial treatment of disabled Danes by examining their institutional care and the 1934 *Mentally Feeble-minded Measures Act or Forced Sterilization Act*. Next, I will explore a shift in the approach to disability. This will be demonstrated by examining the advocacy work of Neils Erik Bank-Mikkelsen and his normalization principle. I will then pay attention to the movement of this advocacy and its influence on the development of sexual policy for individuals with disabilities. This will be illustrated through the examination of Danish policy entitled (translated) *Guidelines about Sexuality – Regardless of Handicap*. Finally, I will demonstrate how the advocacy of Bank-Mikkelsen and this document, have influenced Danish education and pedagogy. Here, I will explore the development of a certification program for social workers and other care professionals, to become certified sexual advisors, recognizing individuals with disabilities and their sexual citizenship.

Chapter 4, “Disability and Sexuality in Canada,” provides a genealogy of disability and sexuality in Canadian culture and institutions. First, I introduce the problematic relationship of disability and sexuality in Canadian policy and the intentions of this chapter. I provide an examination of colonial biopolitics in Canadian history and its construction of disability and its discourse. This will be done by looking at the *Immigration Act of 1910*. Next, I provide a brief exploration of the birth of institutions and biopolitical practices bestowed upon individuals with disability, examining the *Sterilization Act of 1928*. Here, I pay attention to the colonial power deeply embedded in historical Canadian policy and its dangerous discourse of disability. Next, I

turn attention to current institutional practices and the continuity of repressive policy. Here, I explore a current document established by the province of Ontario and its guide for parents of sexuality and adolescents with disabilities, *Sexuality and Developmental Disability: A Guide for Parents* (2021). Using these sites of exploration, I speculate how we might challenge current repressive practices to ensure individuals with disabilities are recognized as fully participating citizens in Canada with their sexuality recognized and accepted.

Chapter 2

Disability Studies

Disability remains visible in our everyday lives through the power relations that are imbedded in our political, social, and cultural practices. This chapter sets the theoretical stage for this thesis. As I explore these various discourses to disability, I turn to Titchkosky, McRuer and McGuire, all indicating that the inclusion and exclusion of disability occurs within dangerous institutional circumstances. Through newsprint, medical texts, and cultures of sexuality, disability is folded into the cultural fabric—sometimes violently, sometimes smoothly.

Disability studies provides both a theory and method to guide this study. I will turn my focus to Michel Foucault, who regards disability as a discursive outcome. Next, I will examine disability through the lens of Alison Kafer who challenges the ways in which the future of disability is currently positioned and assumed. Finally, I discuss the work of Tobin Siebers and the cultural underpinnings of the presently shaped identity of individuals with disability. Next, I transition to the policy environment. This chapter explores the discourses to disability and sexuality denoting its construction through heteronormative dominance. These dominant practices continue to exclude sexuality and disability within current policy framework. To explore sexuality and disability within current policy framework and its lack. The lack of recognition of individual with disabilities and their sexual citizenship status. First, I will turn to the work of Robert McRuer and the cultural understanding of how some bodies matter, and ‘others’ do not.

Robert McRuer: Compulsory Able-bodiedness

My goal in this thesis is to understand the relationship between disability and sexuality within current theory to postulate and examine disability and current absent status of sexual citizenship. This chapter will demonstrate the common discursive landscape of disability and sexuality. Both have been positioned as pathological and politicized to be produced as minority

identities. In this sense, it is through these heteronormative power structures that have shaped, produced, and defined what is dis-abled, deviant, undesirable, and now hidden.

McRuer charts the construction of disability and queerness, deeply rooted in the compulsory nature of heterosexuality and able-bodiedness (2006). Disability has historically been established in multiple cultural and political locations as a problem. McRuer illustrates how able-bodied ideologies and identities have been historically preferred and dominant, constructing the compulsion of able-bodiedness; normalcy (2006). With him, 'we' can ask: What *is* normal? Who defines normal?

McRuer has a grand cultural theory in mind. I want to come up with some tools to talk about disability and sexuality. In that aim, I draw my attention to the medicalization of normalcy, and as McRuer discusses, the compulsory abled-bodiedness. Compulsory ablebodiedness is the system within our culture that produces disability and understands disability by its lack. Consider the infant child that has just been delivered. The medical team that intervenes with its various test that are immediately performed to ensure that the body, is in proper working order. The frequent follow-up appointments to ensure the proper growth of all the body parts; skull size, feet, hands, weight, heart, eye symmetry, and reflexes (to name just a few). These examinations continue for years, until one day there is, (for some), a cause for an *examination*. Something is *alarming*, out of place, a different size, deformed, missing, there is a need to *investigate*. Perhaps now there is a need for intervention, a surgery, rehabilitation. There is a fixed script of how to get things back to 'normal'. Normal for who? Parents and caregivers are reassured that there is a cure, a treatment, to ensure that the child will be normal, healthy again, able. Examination, alarm, investigation: from birth, we encounter institutions that normalize and categorize bodies and their potential deviation.

McRuer argues crip subjectivity emerges in this set of normative circumstances. Western culture turns to our medical advances in interventions, surgeries, and rehabilitation to bring the

person back to its original state, intertwining health and ability while reproducing the able-bodied ideologies and perspectives as preferred. How do we (in popular culture, in medicine, within policy and legislation) eradicate the compulsion of able-bodiedness within current Canadian policy? In that sense, what would the future of disability look like? As I continue to explore the relationship of disability and sexuality in current literature, there are common themes that will be exposed throughout this chapter. Such as, the heteronormative powers that have constructed disability and sexuality to be problematic [medicalized] and does not recognize individuals with disabilities as sexual citizens. Kafer's focus on temporality extends McRuer's work in time, and a common theme we will see throughout this project.

McRuer's work shows that disability has been constructed negatively through compulsory able-bodiedness, disability is thus not recognized as a component of citizenship. Part of that is sexual citizenship, defined as having sexual expressions, relationships, and a sexual life. Disability is regarded as nothing but a pathological problem that needs treatment, intervention, a cure. This dominant understanding of disability, and individuals living with it, is not only confined to the medical arena, but medicalizing institutions, and 'supportive' organizations. For example, the Applied Behavioral Analysis intervention poised at parents for their autistic children so they can *function* effectively. This dominant understanding of disability and sexuality as deviant, sexually inappropriate, behaviors sometimes punishable. Is it possible to eradicate current ableist perspectives regarding disability and sexuality? If so, [not], what does the futurity of disability look like? How will this translate to the politics of disability? Here, I will draw on the work of Alison Kafer, to discuss the ableist assumptions of the future of disability.

Alison Kafer – Assumed Futures

In *Feminist, Queer, Crip*, Kafer (2013) demonstrates the political nature of disability through its many categorical processes, such as medicalizing the individual, and framing disability as a personal problem in need of a solution. Medical guidelines fix the identity of the

person who is now viewed as limited. What future does this person have now, that they have *this* label? This she calls disability futurity, in a negative form. Dominant assumptions indicate individuals cannot possibly have a promising future because they have a disability. This avoids the distinction between the temporality of impairments and of disability. These labels and categories, diagnosis, or prognosis, as Kafer illustrates, will predict the future of disability, one of which no one wants (2013). What is the future of disability if we continue to exclude it from our future?

When thinking of a ‘promising’ future, typically our focus is on the younger generation that will be entering post-secondary school, becoming the continuum of future economic contributors, policy makers, and politicians. A typical trajectory: young adolescents working hard throughout their high school years and the associated upcoming rite of passages. Their assumed relationships, marriage, future children, higher education, and successful careers. Here, I ask, who is the future promising for? Are students with disabilities given the same support, encouragement, and opportunity for success as their able-bodied counterparts? Who has an accessible future in this sense? We (in popular culture, in medicine, within policy and legislation) must ask: why is it that teens with disabilities do not attend sexual health class like their able-bodied peers? While ‘we’ continue to exclude disability throughout policy and practices regarding sexuality, relationships, and reproductive rights, we continue to reproduce the discourses to both disability and sexuality. How does this translate, shape, and produce disability and identity to a sexual minority?

Tobin Siebers – Disability and Minority Identity

To understand these questions, we must explore the relationship of disability and sexuality and the discomfort within western society in recognizing individuals with disabilities having a sexual status. Here, I will draw on the work of Tobin Siebers (2011), while exploring

minority identity, how identity is shaped, and how this translates to individuals living with disabilities as a sexual minority. The historical and political constructs of our knowledge of sex, bodies, and ability has laid the foundation of cultural and social perspectives of each. These constructs have produced disability to be a medical matter that is defective, inferior, and something to fear. Disability becomes another category for social control and exclusionary practices within policies and institutional environments. Who determines a quality human being? What does it mean to have a quality of life? Who determines what that *quality* is? The continuity of medical labelling and categories developed by able-bodied experts of how we understand our bodies, gender, sex, and disability; has created cultural and minority identities by doing so.

As Siebers (2011) demonstrates, disabled sexual identities have been politicized and shaped through heteronormative beliefs and practices. This translates to a minority identity, like those based on race, gender, sexual orientation, and ability. These minorities, according to Siebers, were critiqued to have unhealthy identities and who were repeatedly rejected due to their minority [inferior] identity (2011). In this sense, minority identity has been constructed by and for dominant culture, oppressing and marginalizing groups from society through non-recognition or denial of social and civil citizenship. As Siebers illustrates with an example of a ‘school/program’ for special education for disabled children, Del Sol Academy, that is not recognized by the state of California, refusing to provide report cards for programs that educate children with disabilities (2011). What is needed, in his view, is a positive identity politics for disabled people, and an according sexual culture.

Consider the dominant control over sex and reproduction. Sex and the body are considered to the act and apparatus, two main ingredients between a man and woman to reproduce one’s quality and characteristics onto their kin. The body and sex were viewed through a medical lens, labelled body parts on diagrams advising the reader of specific exterior and interior regions of the male and female body that will eventually lead to fertilization. In fact, it

was well known practice to sterilize those who did not meet societal expectations of ‘quality’ or ‘healthy’ such as individuals with disabilities. Control over identity expanded into control over body and sexuality. The feeble-minded were regarded as a menace, unable to parent properly, sexually deviant, a ‘thing’ society does not want to have reproduced. Sex, or sexual culture, as Siebers (2011) describes, comes from these ableist ideologies that have historically, politically, and culturally discriminated, and oppressed individuals with disabilities. In their exclusion of sexual citizenship, individuals living with disabilities have had their social, civil, and sexual needs ignored.

If following Siebers, we consider disability as a minority identity, so too, should we consider disabled people as a sexual minority. The dominant discourse to identity has created movements that have made shifts in social, civil, and sexual citizenship. Consider the strides that the LGBTQ+ movements have made within Canadian political culture. Access to the rights to parenting, the right to privacy/access of sex, same-sex marriage, and adoption are all examples of these cultural shifts in recognizing a minority group and their rights to social equalities. However, these rights mentioned, are still not considered for individuals living with disabilities. These institutional landscapes continue to construct minority identity without sexuality included. Rights and citizenship are an important aspect of disability politics, which I will explore below.

Michel Foucault – Dangerous Discourses

This project examines dominant contemporary discourses and the power relations that define and construct disability within Canadian society. The outcome is the inability for individuals with disabilities to attain socio-sexual citizenship. My approach is to challenge current heteronormative and cultural dominance that denies disability and sexuality within Canadian policy and law, and I will turn to Foucault to challenge these discourses. Foucault’s interest in political relationships of power and knowledge and the historical contours that have

shaped sexuality as problematic, inspire me to ask under these conditions, is it possible to consider policy change that will support individuals with disabilities access and opportunity to their own sexuality in Canada?

Foucault's focus on power and knowledge can be applied to disability. He shows how historically, disability has been constructed and produced as a problem, something to avoid, in need of intervention, while these fragmented ideologies are entrenched in current socio-political policies and practices. However, this power of oppression does not just engross individuals that have disabilities; the same historical structures have shaped our truth and understanding of sexuality, our bodies, which are managed by these power relations that continue to monitor or immobilize our sexual citizenship.

Foucault's argument is that the way we talk about sex has been guided by the church, clinic, and state. Sex is deployed by power, not just restricted by it (1978). As Foucault describes, "...that in every society the production of discourse is at once controlled, selected, organized and redistributed by a certain number of procedures whose role is to ward off its power and dangers, to gain mastery over its chance events, to evade its ponderous, formidable materiality (1970, p. 52), Moreover, Foucault demonstrates how crucial it is to speak about these discourses, to rewrite current knowledge and understanding of sex/sexuality to better understand how our sexuality is a historical outcome (1978). Consider this dogma establishing its power, control, and manipulation of the sexual knowledge of women, medicalizing and oppressing the truth and knowledge of sex, desirability, and the erotic lives of women's' embodiment. Foucault's goal was to show that sex had a history. Now, this is something that is crucial to our lives, but, it has not always been this way.

The history of biopolitics has deployed sex as a scientific outcome, mapped on the human body. Sex is marked by a reproductive etiology, accompanied with materials that outline and sketch to its reader the anatomy of the female body; the science that exposes the interior

instrument that will metamorphosize itself once the oocytes have been fertilized. The female body became a *system* in need to be labelled, defined, categorized, constructing the individual into a moral object. It is a moral object, whereby attending to sex is merely to reproduce. Why has the female body been constructed as a moral object, and not as an individual with various erogenous zones that can be explored by oneself or with their partner? The fear and evil danger of exploring sexuality was embedded in moral and medical institutions and practices, leaving the power of knowledge and truth of our own bodies to the structures that created them. The historical discourse to sexuality and its objectification are analogous to the historical and current discourse of disability. It has condition disability as a problem, something to avoided or eradicate at all costs. In looking to medical text, we find a corollary in Titchkosky, who asks us to see how disability manifests in the life of print.

Tanya Titchkosky – Production of Disability

The history of disability, from the Foucauldian perspective, looks to a history of problematization. How is disability made a problem, and how does this represent a barrier to disabled people? I ask, how are discourses reproduced simultaneous to both sexuality and disability into our everyday lives? With this question in mind, I will draw on the work of Titchkosky and the examination of how disability is textured as both a social and medicalized problem. This examination will expand on the medicalization of sexuality as previously discussed, as well as the publicly produce forms of media that continues to contour our understanding and meaning of disability.

Titchkosky's *Reading and Writing Disability Differently* examines various texts through media and medical archives that represent disability as a medical problem in need of a cure, to be fixed, or eliminated (2007). Texts that reproduce disability as a problem have been created by the same power structurers that personify sex or sexuality as problematic. Following Foucault, these dominant western discourses have shaped the truths of how we understand sexuality. My previous

example focused on the manipulation of the women's body as a system of parts, an object, merely for the reproductive expectations of dominant cultural beliefs, not as a source to experience desire and pleasure.

As Titchkosky looks to newspaper articles, arguing disability is always read as a problem. Similarly, I would suggest that the current textured discourse medicalizes and labels the body, women, and disability, each as an object that is defective or capable of producing it (2007). These discourses are reproduced in newspapers, medical journals, and other literary materials, that continue to shape cultural understandings, knowledge, and truths of disability. Consider the female body, as discussed earlier, as the object for biological reproduction, the scientific purpose behind the physical individual. The body and its parts, the womb, now hosting the fetus that becomes another object to manipulate and control. The medicalization, power, and control we have seen manifest in texts on screening and risk, to ensure that disability is not reproduced. The pamphlets and brochures for women to undergo a medical procedure to verify whether the fetus the body is hosting, is defective, abnormal, some 'thing' as wrong. To this end, Emily Martin (1995) investigates 19th century biology texts on the body and how they are positioned in power/powerless positions. Martin (1995) states, "Learning that our bodies are made up of hierarchically ranks kinds of cells, left dumb, uncouth, barbaric 'females' at the bottom and smart, educated, civilize, executive 'males' at the top, has its part to play in showing us why it is alright to think that some kinds of people are not as worthy of life in human society as others" (p.133). Manipulated by science and technology, the women's body is not only the apparatus for biological reproduction, but it also now becomes the petri producing a problem. An assumption is being made here: having a child with a disability needs to first be informative of a problem that needs medical attention.

Consider the textual output of an abnormal ultrasound, prenatal screening blood tests, pamphlets or brochures regarding a prognosis, or definition of the potential abnormality in need

of elimination, continues to medicalize disability as a problem. These renderings of disability are not limited to the medical world, in fact, as Titchkosky identifies, textural spaces are intensely wide-ranging (2007). Newspaper articles, posters, commercials, charity boxes, government and medical pamphlets, inclusively produce disability as an objective marvel. Together, Titchkosky and Foucault, call attention to the written materials that are to educate, make aware, and define the meaning of disability and sexuality, providing to its reader how both are problematic.

The expectations of the body and its sexuality, become compiled by a variety of texts, labels, categories, images, and messages that describe to its reader the problem. Titchkosky demonstrates how the discourse of disability is reproduced in our everyday lives by the various text that we interact with. This is similar to what I have illustrated examining the work of Foucault, and we will see it as we turn to McGuire. The historical, political, and cultural renderings of both sexuality and disability have constituted their appearances as a problem. Why do power structures continue to write about disability and sexuality as merely a ‘thing’ to avoid? Why do we (in popular culture, in medicine, within policy and legislation) continue to partake in the process of identity formation by these negative narratives? Under these conditions, is it possible to consider policy that will support individuals with disabilities access to experience their own sexuality and the opportunity to encounter sexual relationships?

Anne McGuire – Cultural Failure

McGuire uses Foucault’s work to show the discourse of disability and deficiency present in autism advocacy. McGuire’s approach examines an extensive collection of various cultural materials of newspaper articles, pamphlets, policy documents, all of which profess to be informative materials in obtaining knowledge and understanding of autism (2016). This discourse characterizes autism as being a biological, pathological problem of individuals who need to be cured, a problem to be fixed, and eliminated (2016). These pathologizing texts were developed and distributed by various organizations that claim to be advocates of those living with autism

and their families. These materials are to help in the advocacy for better access and more services for individuals living with autism, that are desperately needed to eliminate the stress and potential crisis situations families of autistic children endure.

McGuire demonstrates that autism advocacy and its dominant eloquence of autism, does not truly advocate for the autistic individual, in fact quite the opposite. These informative cultural materials create autism as an object, problem, a thing, that is causing the stress and crisis in the lives of those who are living with them (2016). Autism, the ‘thing’, is separated from the individual as the problem that has made the child deviant, the source of stress, or the medical problem in need of a medical solution. In this sense, as McGuire suggests, advocates are reproducing the ableist, normative, medicalization of autism and the continuity of social and structural violence for those who are living with autism. I would like to extend on McGuire’s examination of these cultural materials that attempt to provide information on autism, with its categorical signs and symptoms to be made aware of and to fear. The materials that are distributed by various autism advocates and organizations that dominate parents and caregivers, campaigning the urgency for early intervention programs to eliminate or eradicate the disturbing, deviant, and violent behaviors children with autism display. As we talk about disability and sexuality throughout this project, I ask, why does dominant western society fail to consider that one’s disability coincides with one’s identity? When a child is diagnosed with a disability, the child becomes labelled a ‘thing’ or now has a tangible ‘problem’ that is now ‘devastating’. Parents or caregivers are immediately devastated, shocked, or in disbelief of the words they just heard, yet, within those very seconds, nothing of that child has truly changed. The individual had the disability prior to the announcement, so why does the child now become an object? There is a shift in focus on the *problem*, (the labelled diagnoses) and no longer on the child and their identity. The child becomes the ‘autistic’, ‘deaf,’ limited, restricted, behavioral. Why do we (in

popular culture, in medicine, within policy and legislation) consider the ‘dis’ in disability to be the *flaw*?

Given this pathologized context, it is not surprising that disability and sexuality are divided in the Western political context. Here, McGuire traces Western norms of disability exclusion through the inclusion of autism as a problem. Is it possible to challenge these dominant underpinnings that devalue individuals living with disabilities within various forms of ‘informative’, ‘factual,’ and ‘advocacy materials’ that continue to produce disability as a ‘thing’ to fear, fix, or eradicate? I will discuss further how these dominant power structures reproduce disability through these images and text as McGuire demonstrates, by determining when to exclude and include disability within material we read, write, and observe.

Throughout this chapter I have alluded to the institutional history of disability in Canada. I hope to have demonstrated the cultural and political underpinnings that determine when and where to include and exclude disability – in most cases, as a problem. The power to choose when an identity will or will not be recognized, visible, and validated as more than a pathologized and politicized problem. Consider the role of those trusted to inscribe disability in everyday life. In this sense, I turn to current policy and practices within Canadian legislation. I ask, what current policies and practices include or exclude disability from its dialogue? Are current policy and practices supportive of disability and sexuality within its framework?

Here, I cannot but ponder on the many sexual liberation movements, especially within the LGBTQ+ communities in Canada. These movements passed legislation and policy that once denied and punished their citizenship status due to their sexuality/orientation. These actions led to the right to express sexuality openly, without punishment, partner choice despite sexual status, parenting rights, and same-sex marriage. These rights have been coined as sexual citizenship. As I discussed earlier it is imperative that we consider individual with disabilities also as a sexual minority. Why are individuals with disability not included within legislature or policy with the

same rights to their status as sexual citizenship? Here, I will transition to the policy environment and examine the work of Richardson and Prince with a critical theory of disability with its framing in policy spaces, looking to sexuality.

Diane Richardson – Sexual Citizenship

Western knowledge of sexuality has been constructed through heteronormative practices primarily focused on the medicalization of the body. Historically, sexuality has been positioned to be something devious, corrupt, secretive, a ‘thing’ we do not talk about. We need to expand here, a normalizing discourse of sexuality into the thing we can express and speak about. Sexuality has become a landscape for various discourse and plays a significance role in the development of sexual citizenship. Drawing on the work of Richardson, the concept of sexual citizenship has become contested in various ways. While trying to understand how people claim sexuality relative to political identity, I will draw on the work of Richardson, and her work on sexual citizenship. Although this is not an inclusive summary of Richardson’s work, I believe while we attempt to understand sexual citizenship and political identity, we must be diverse in our ideologies of current sexualized landscapes and its various intersectional discourses.

Who is considered to be a good citizen? The normal citizen, as Richardson illustrates, is a heterosexual citizen (2004). Civic participation and rights are grounded in heteronormativity. Take, for example, gay men and lesbian women who want to be recognized with the same rights and responsibilities as heterosexual couples, with claims of equality on grounds of ‘sameness’ (Richardson, 2004). Throughout history, experts established homosexuality as a sexual ‘other,’ abnormal, inferior thing to be treated and cured. Richardson (2004) demonstrates that these various forms of social exclusion and marginalization of the sexual ‘other,’ [homosexuality], continues to reproduce the heteronormative social and structural barriers that sexual minorities may experience.

Like disability, citizenship is made possible through institutionally entrenched discourses. However, it is important that while we examine sexuality and normalized citizenship, it is crucial that we include the discourses to disability, sexuality, and citizenship. Sexuality and citizenship are much more than gender-based or sexual orientation based within its discourses. Individuals with disabilities, like the LGBTQ+ community, have longed to be recognized (like their able-bodied counterparts) as being sexual and desirable, having access to their sexual identity. The gay liberation movements were expressing their concern of exclusion to the right to sexual liberation and freedoms, based on their sexual status (2000). However, it is critical not to limit sexual status or citizenship to gender or sexual orientation. Here, it is critical to ask why individuals with disabilities and the rights of sexual citizenship continue to be ignored?

Sexual rights are an important part of our sexual citizenship. Sexual identity becomes the footing for the exclusion or inclusion of categories within citizenship. Richardson illustrates further, within current social policy, there is limited theorizing of the relationship between sexuality and social policy and the crucial need to expand on citizenship and its relation to sexuality (2000). Consider relationship-based rights and the right to engage in sexual relations with others. Richardson draws on the age of consent that legislations has defined at what stage an individual is valued or regarded as a sexual citizen and the right to partake in sexual activities within one's relationship (2000). In this regard, legislation, law, and policy have predetermined a particular age one has the right to encounter sexuality and sexual intimacy. How does this translate to individuals with disabilities? What considerations here, are made for accessibility and facilitation for individuals with disabilities to secure sexual status? It is critical that while we discuss, define, and theorize the relationship of sexuality and social policy, we (in popular culture, in medicine, within policy and legislation) must extend beyond the mainstream binary of gender and sexual orientation. Disability is insufficiently in this discussion. These exclusionary practices reproduce the current discourses to disability and sexuality.

We must ask, with Richardson, where do we exercise sexual citizenship? Here, Richardson points us to the important of spaces, such as the private to declare sexual citizenship and the public for recognition (2017). Barriers within these ‘spaces’ have been created through dominant heteronormative underpinnings, marginalizing individuals within these two communities by restricting access to sexual citizenship. These structural regulations through institutions, policies and law have defined what is personal/private space and which is public. For example, Richardson illustrates that these spaces become further controlled or regulated for individuals in the global south who may not have access to privacy, or limited access to public spaces that further oppresses their sexual citizenship (2017). However, social, and structural barriers to sexual citizenship should not only focus on gender/sexual orientation or global location. We must also consider how this translates to individuals living with disabilities. As Richardson (2017) demonstrates, the private sphere and the right to privacy for some, may be the footing for their right to sexual citizenship. However, for many individuals with disabilities, the public sphere of sexual citizenship may be the framework for access to sexual citizenship. We (in popular culture, in medicine, within policy and legislation) must consider how the private sphere of sexuality and disability has been institutionalized, made private through the monitoring and control of individuals and their sexual expression/identity. In this way, public and private space is created through the dominant heteronormative able-bodied practices that force sexuality to be a private, shameful matter for individuals with disabilities. While, to have sexual expression, sexual identity, or to be considered as a sexual body, the pursuit of the recognition must be done through the public space to enlighten the state that individuals with disabilities have erotic lives.

The public/private distinction allocates access to sexuality. These corporeal rights and freedoms as Richardson illustrates with steps toward a discussion of embodiment through a trans-political lens. Richardson’s (2017) example of LGBTQ+ communities and the restrictions to sexual expression/identity, along with the right to same-sex marriage, adoption, and parenting

rights. However, Richardson has overlooked these same discourses for individuals living with disabilities and the indistinguishable struggle for corporeal identity/politics. Individuals with disabilities, both in private and public spaces, have a long history of being scrutinized and punished for expressions of sexuality or sexual desires, like the LGBTQ+ communities. Ableism has shaped how embodiment is connected to identity through social, cultural, and political practices. However, this discussion of sexual citizenship (and its exclusion of disability), reproduces the discourse to sexuality and discourses to sexual citizenship continuing to oppress individuals with disabilities and their embodiment. I consider this to be a continuity of heteronormative discourses that currently enables the discourse of individuals with disabilities and their sexual citizenship.

The historical production of hegemonic ideologies that determine who is 'able' or 'considered' to have sexual relations continue to oppress sexual citizenship to various minority identities. This can be demonstrated through Canadian policy, such as, The *Sterilization Act of 1928* and individuals with disabilities along with other minority groups we will examine later. As I continue to examine how individuals claim sexuality (or not), it becomes apparent how we read and write about sexuality continues to oppress corporeal identity and politics for individuals with disabilities.

As we read and write about discourses to sexuality and discourses to citizenship, it is crucial that we incorporate the discourses to disability in the same discussion. Richardson demonstrates the historical exclusion of gays and lesbians from being full citizens as these relationships were non-reproductive and were not considered to be full participants within society (2017). Should we not consider the historical exclusion of individuals with disabilities? To do so, we must explore the medicalization of disability, the institutionalization of disability, and eugenic practices, whereby individuals with disabilities did not have a *choice* to be reproductive. In doing so, we can ensure we do not reproduce heteronormative views on sexual citizenship that will

further marginalize sexual minorities. How do we (in popular culture, in medicine, within policy and legislation) incorporate sexual citizenship within practice and policy in Canada with roots so deeply embedded in ableist attitudes and beliefs?

Michael Prince – Status of Citizenship for who?

To this point we have discussed the social, political, and cultural construction of disability as a medical and biological problem. In this context, the current struggle to attain the status of social, civil, and sexual citizenship for individuals with disabilities, remains embedded within our institutions. The definition of citizen was created within these hegemonic undertones, was based on exclusion. What qualities and attributes are required to be considered a citizen? What is inclusion and equality within Canadian policy for minority groups? How does current 'inclusion' and 'equality' for minority groups and citizenship within Canadian policy and legislation translate to individuals with disabilities? How will this translate to attaining status of sexual citizenship?

Prince's (2009) *Absent Citizen* allows us to examine citizenship and the struggles individuals with disabilities have in defining and attaining such status. Existing Canadian public policy is largely based upon the medical model encompassing disability as a 'thing' to be cured, fixed, and charitable dependency. These same historical power structures created policy and legislature that deemed individuals with disabilities as a burden to society, deemed unemployable, mandatory segregation and forced into special schools (Prince, 2009). Current disability movements, as Prince illustrates, are rights-seeking minority groups, demanding the government take responsibility for exclusion, and recognize their claims to equal citizenship (2009).

Prince argues Canadians with disabilities have always been absent citizens. Here, I will draw a corollary to the experience of Indigenous peoples. Indigenous people were a threat to white superiority, whereby Canadian state power introduced policy and legislature to eradicate

and eliminate Indigenous populations. They were deemed a threat to society, a population to fear, the ‘thing’ that should not reproduce. Colonial policies, especially the Indian Act, created institutions such as residential schools that sought to isolate Indigenous children from their families and traditions to assimilate to the dominant culture. Forced sterilization, medical experiments, and reservation systems were created under state law to marginalize this population. Continued years of stigma, oppression, and marginalization which has created inter-generational trauma in current Indigenous communities.

While we consider Canadian policy and legislature and citizen status; it is crucial we recognize the history of violence and othering, through the ongoing colonial project. While great strides have been made for Canadian Indigenous communities and their citizenship, the impact of the trauma experienced remains. The term ‘recognition’ has been used often between the government of Canada and its Indigenous communities, as a lip service (Coulthard, 2014). However, what does recognition by the state entail? Recognition of whom or what? Does being recognized then give you status of citizenship? It is my belief we can extend this criticism of colonialism to the colonial biopolitics that continue in Canada today, and shape our understanding of disability. We will see more of this in the final substantive chapter of this thesis.

Throughout this chapter I have discussed sexuality and the ideology of ability (Siebers 2006). I have illustrated that disability is the outcome of deadly discourses. I also demonstrated how sexuality has been positioned in the same way. This brings me to question what cultural and social shifts took place in Denmark advancing current legislative/policy acknowledgements of individuals with disabilities and their sexuality? What ethical and political progressiveness was required to make policy change for the awareness and justice of individuals with disabilities to achieve status as a sexual citizen in Denmark? Although considered to be politically radical, how did Denmark achieve such social and cultural support within policy and legislature that

encourages the engagement and assistance of sexuality and experiences for individuals with disabilities?

Chapter 3

Denmark: Sexual Politics from Medicalization to Affirmation

As I demonstrated in the previous chapter, cultural and political power structures have constructed the current Western discourse of both disability and sexuality. This is critical to our understanding as to *why* the relationship between disability and sexuality is one of exclusion within Canadian policy. Those in positions of authority and influence, decide when and how disability is written and is done so in a pathological manner. In doing so we fail to discuss or validate sexuality in an affirmative manner, reproducing the exclusion that has created these discourses in the first place. Have other countries face similar discourses to disability and sexuality? What challenges, if any, are like Western society? Has there been success toward discursive discourses toward disability and sexuality? With these questions in mind, I will turn my focus to Denmark and examine these inquiries.

Medicalization and Institutions:

Historically, Denmark's political and social systems have viewed disability as a medical problem in need of intervention, isolation, and segregation. However, there was a discursive shift, toward de-institutionalization, and eventually sexual citizenship for Danes with disabilities. The aim of this chapter is to demonstrate a prodigious socio-political movement that took place in Denmark seventy years ago, leading to a progressive and supportive identity politics for people living with disability, affirming their sexuality as equal citizens. However, it is important to note that unlike various social movements, this was not initiated by the community of those living with disabilities, nor did it stem from protests or activist calling on government recognitions of systemic barriers or disadvantages that we typically witness with other popular movements (Kulick & Ryström, 2015). The movement I explore in Denmark, began with disability activist Niels Erik Bank-Mikkelsen, within state institutions. This case study draws most heavily on the

work of Kulick and Rydröm (2015), through their historical archival research and empirical methodologies, demonstrating a social movement unlike any other for individuals with disabilities and sexual liberation. This surge that took place in Denmark within its cultural dogma, initiating supportive shifts in social policy. Being that the state recognizes the important relationship between disability and sexuality, as a basic human right regardless of one's disability (Kulick & Rydstrom, 2015).

Like the institutional environment described in the previous chapter, Denmark's modern disability policies were founded upon the medical model of disability. This meant the medicalization and confinements of disabled Danes up to the 1960s. In Denmark, the medical model was practiced mainly between the period of 1930-59. Discourses to disability were reproduced through language, policy, and systemic barriers through dominant heteronormative practices. People with disabilities are often thought of as sexually deviant, asexual, or as having sexually inappropriate behaviors while trying to explore or express their sexuality or desires (Berman et al., 2009; Brown & Russel, 2005; Earle, 1999; Shildrick, 2007). Individuals with disabilities would be punished for such expressions by being put in restraints, subject to lobotomies, and electric shock therapy as forms of discipline for their desirability (Kulick & Rydstrom, 2015).

It was common in the 1930's for doctors to sterilize individuals with disabilities without their permission and in fact was encouraged. The *Mentally Feeble-minded Measures Act or Forced Sterilization Act* was passed in 1934 which gave institutions the option to forcibly sterilize their occupants. We read:

Section 5 . The relevant institution management must as soon as possible make a recommendation to the committee referred to in § 6 regarding the undertaking of sterilization, cf. § 7, of a person with mental retardation, when societal considerations, such as the fact that the person concerned due to mental retardation is deemed not to be able to properly raise their children or to provide for them through their own work, advocates that the mentally retarded person be put out of business to have offspring, or when Sterilization will be beneficial for the mentally retarded person himself, as

Sterilization will make it justifiable to refrain from involvement in care or will enable the mentally retarded to transition:

- a) from institutional placement to supervised family care or discharge,
- b) from controlled Family Care to Discharge or
- c) to a freer form, respectively under institutional placement or controlled family care.

(MFMA, Denmark, 1934)

We can connect these practices to my previous chapter, discussing the medicalization of disability within Western culture.

These eugenic principles began to shift around the late 1950's emerging a new theoretical approach to disability throughout Scandinavian countries known as the Normalization Principle (Kulick and Rydström, 2015). This innovative approach was developed by Denmark native Niels Erik Bank-Mikkelsen, an activist and advocate for people with disabilities. The normalization approach insists that individuals with disabilities deserve the opportunity to have lives as normal as their able-body counter parts, which, also included their sexuality (Kulick & Ryström, 2015). This alternative model began a movement leading to changes in legislation and social policy, incorporating and recognizing the sexuality and erotic lives of individuals with disabilities and their individual needs.

The normalization approach challenged the then-dominant punitive approach, common within Danish institutions. Lobotomies, restraints, sterilization or libido-inhibiting medications were common at the time, denying disabled people their sexual desires and the ability to express them. Niels Erik Bank-Mikkelsen, one of the most influential figures advocating for the normalization of people with disability, did so by challenging institutional care, living conditions, and the forced sterilization of people with disabilities was a common practice (Kulick & Rydström, 2015). Bank-Mikkelsen at this time was working for the Danish Ministry of Services and began to utilize his power and influence to sway others to consider the normalization principle for individuals with disabilities. He did so by discussing sexuality and disabled Danes in

various meetings and conferences, such as the Danish parent group, National Association for the Well-Being of the Feeble-minded. This led to others agreeing within these meetings and left those in attendance asking why they have not thought of sexuality before (Kulick & Rydström, 2015). The first task was to address the forced sterilization of individuals with disabilities by addressing sexuality.

In a call to action around these issues, Bank-Mikkelsen, then head of the State Services for the Feeble-minded, decided that their 1967 annual conference with the National Board of Social Services would focus on sexuality. The conference was attended by staff from institutions, teachers, parents, medical professionals, and social workers. Here, Bank-Mikkelsen discussed these intolerable practices and cruelty against those living with a disability in institutions, criticizing eugenics, use of restraints, and forced sterilization (2015). This would be the first movement in Denmark to challenge the medicalized discourses on disability and towards sexual citizenship. As these challenges of forced sterilization began, so too, did the acknowledgement that individuals with disabilities had a right to their sexuality (2015). These historical processes changed the lives of those living with disability in Denmark, to be recognized like their non-disabled counterparts as having sexual rights, being able to access sexual education, sexual facilitations, and sexual advisors as a basic human right to be supported by the state.

Once Denmark began to challenge institutional practices, policy changes and attitudinal beliefs shifted to acknowledge and respect individuals with disabilities and their sexuality. Looking to the chapters to come, we might ask: while Canadian government also shut down the practices of forced sterilization and eugenics, why did they not move to the full sexual citizenship of disabled people afterward? Why did we (policy, medicine, legislation, education, various media) not consider policy change supporting sexual citizenship for individuals with disabilities? While challenges were made to the treatment of individuals within institutions, why did we not challenge the lack of sexual health, sexual education, or potential sexual lives of those living with

disabilities? Here I argue Canada has much to learn from the Danish experience. With that said, we turn to the process through which sexual citizenship for disabled people emerged in Denmark, dismantling the medicalized discourses of disability and sexuality found before the 1960s.

Dismantling Discourse in Denmark:

Bank-Mikkelsen positioned disability as a political problem and argued that society must change and challenge the conditions and treatment of individuals with disabilities. His power from within social structures and policy, allowed him to press the normalization reform with support of like-minded individuals who were advocating and working with individuals living with disabilities (2015). This began with the de-institutionalizing of these spaces and social policy within Denmark legislature. Denmark, in 1959, began to see a shift from the medical model within policy and practices, to the normalization reform.

In 1959, Bank-Mikkelsen inscribed the principles of normalization within the *Act Concerning the Care of the Mentally Retarded and Other Handicapped Persons*, ensuring that those living with disabilities were able to obtain the same legal rights and citizenship as others.

The purpose of a modern service for the mentally retarded is to “normalize” their lives. [...] To provide the retarded with normal life conditions does not mean that we are oblivious of our duties to offer special care and support. We simply accept them as they are, with their handicaps, and teach them to live with their handicaps. Whatever services and facilities are open to all other citizens, must, in principle, also be available to the mentally retarded (p. 234).

With the *Act* Denmark became the pioneer and leader of the normalization principle in social policy. This shift shuttered many institutions for their inhumane practices and treatment of individuals with disabilities. Further, the *Act* reformed current responsibility of the institutional care of individuals with disabilities to be under the State, rather than in private institutions or homes. The aim was to remove individuals from institutions and provide smaller group homes that were more home-like environments throughout different regions in Denmark.

The normalization principles embedded within the *Feeble-minded Act* of 1959 altered the structures of education as well. Education of the deaf, blind, and intellectually impaired youth became a state responsibility, rather than a private one. Normalization heralded changes within Danish social policy and institutional reform. While this emergence created many changes to policy for individuals with disabilities, it was not until the 1967 conference held by the National Board of Social Services that significant transformation truly began.

The 1967 Nyborg conference focused on the sexuality of individuals with disabilities. Teachers and social workers, inspired from this conference, began to write public letters to the *S.A – Paedagogen*, a journal for teachers working for the State Services for the Feeble-minded. In these letters, staff were curious as to who was going to teach their students with intellectual disabilities how to masturbate when they did not know how, expressing an interest in doing so (Kulick & Rydström, 2015). This question sparked some serious debates and a furious response from Gunnar Wad, director of the *Hammer Bakker Institute for Individuals with Intellectual Impairments*. His response indicated that anyone who helps in the training of an individual with disability to masturbate would be charged with sexual abuse (Kulick & Rydström, 2015). Bank-Mikkelsen was also quick to reply in turn. First, he thanked the teachers and social worker for posing such a crucial question. He then reassured the reader that there is no criminal act while helping people accomplish activities they cannot manage on their own (Kulick & Rydström, 2015). Here we find the first extension of the normalization principle to sexual citizenship.

In 1966, Bank-Mikkelsen published an article outlining what would then become the framework to the guidelines of sexual facilitation for individuals with disabilities. The creation of this doctrine was based upon the same fundamentals of the State Services of the Feeble-minded. The goal was for people with disabilities to have a better life, similar to their able-bodied counterparts. These fundamentals, often referred to as “Bank-Mikkelsen’s Six Commandments” outlined the roles and duties of professionals working in the company of individuals with

intellectual disabilities and their sexuality (Kulick & Rydrström, 2015). The six commandments are as follows:

- to provide sexual education that respects the fact that people receiving it have intellectual disabilities,
- to instruct about sexual practices,
- to provide access to family counselling and to help regarding marriage,
- to inform about contraception, including recommendations of voluntary sterilization, where appropriate,
- to arrange the living conditions in institutions so that it will be practically possible to have a sexual life,
- to inform about the rights of the clients in this area, in order to create better understanding of these aspects of human rights in the general population, and among parents, relatives, and staff. (Kulick & Rydrström, 2015, p. 57).

This document has forever changed the lives of individuals with disabilities and their status to sexual citizenship in Denmark. Here, I will focus on the development of such policies and practices that emerged from these Commandments giving the opportunity to Denmark's community of people with disabilities to explore, express, and attain their sexuality.

Recognition of Disability and Sexual Status:

Following the six Commandments and the Nyborg conference, questions and concerns about disability and sexuality were beginning to be recognized as an important part of the lives in individuals with disabilities. Here, it is crucial to ask: how does sexuality and disability become recognized? How was this relationship put into practice? Continuing his attempt to find ethical and respectful ways for individuals to capture their sexuality, in 1972 Bank-Mikkelsen ordered the educational section of the Social Services of the Feeble-minded to begin working on the sexual rights for individuals with disabilities (Kulick & Rydrström, 2015). The recruitment process then began for teachers who were interested in these topics, bringing two key figures to the table for the advocacy for the sexual rights of people with disability: Jorden Buttenschøn and Karsten Lot (Kulick & Rydrström, 2015).

Together, Buttenschøn and Lot developed several courses for individuals with intellectual impairments and those caring for them. Presenting material to teachers and social workers with a 4-step plan created in 1974 for supporters to practice. This included establishing;

if an individual's frustrations could be connected to sexuality; if so, create a plan to education individual; plan must be approved by staff; and the plan must also be approved by a parent (Kulick & Rydström, 2015).

The fourth step did not sit well with members of a parents' group, who argued that they do not want to know about their children's sex lives as the subject is meant to be a private matter. This debate resulted in the Social Services replacing the fourth step with the plan shall be approved by the individual themselves (Kulick & Rydström, 2015). This became the starting point of the recognition of disability and sexuality as a formal relationship managed by the client.

In 1986, Løt passed a bill to address the Assistance Act, proposing reforms must be made regarding individuals with disabilities. Developed in 1974, the suggested reforms were not only for disabled people's pensions, how or where they choose to live, but included considerations to sexuality (Kulick & Rydström, 2015). Løt's political party's proposed three areas the government must act upon:

1. Developing guidelines concerning sexual education and training of people who live in institutions
2. Investigating whether sexual education for people with disabilities, and assisting them in other ways with their sexuality, would be prosecutable under existing penal code
3. Present a plan for how sexual counseling for people with disability might be expanded and improved (p.66)

Here, the National Board of Social Services was advised by the Ministry of Social Affairs to begin the preparations of a report that would become the framework for conducting the above recommendations. In October 1986, the report was complete. It was graphic in detail, accounting for the cruelty that individuals with disabilities experienced if they sparked any interest in their sexuality (Kulick & Rydström, 2015). The cases investigated proved that any relationship between disability and sexuality were prohibited and punished. Individuals were put into

restraints and subject to several lobotomies to intervene their deviant behaviour of sexual expressions (Kulick & Rydström, 2015).

The report asked: “May the staff in a corresponding situation help two physical handicapped people have intercourse if they can’t manage to do it on their own?” (p. 66, Kulick & Rydström, 2015). This was intended to demonstrate individuals with disabilities are sexual, and it is crucial to support their access and opportunity to have erotic lives. The report continues to highlight the need for guidelines permitting people who are assisting individuals with disabilities and their sexuality, the ability to do so without criminal charges. Moreover, the report calls on the government to action and devise a plan of how to elaborate on current sexual education throughout Denmark (Kulick & Rydström, 2015). The document’s calls to action led to a prompt retort by the Ministry of Social Affairs advising its board members that a guideline must be created for how staff working with individuals with disabilities could assist with their sexuality. It is important to note that Bank-Mikkelsen was not involved in the creation of the guidelines. However, I hope I have demonstrated throughout this chapter, the determination and advocacy of Bank-Mikkelsen had made these political, cultural, and social shifts for decades. His drive and passion to have individuals with disabilities attain full citizenship like their able-bodied counterparts set the framework for the 1989 *Guidelines About Sexuality – Regardless of Handicap*, that the Board of Social Services presented (Kulick & Rydström, 2015). Both Karsten Løt and Jørgen Buttenschøn were points of references, among other representatives, that helped in the creation of the first *Guideline* involving sexuality and disability.

The *Guideline* introduces sexuality as follows:

- Sexuality is an integral part of every person’s personality.
- It is a basic need and an aspect of being human that cannot be separate from other aspects of life.
- Sexuality is not synonymous with intercourse. It is not about whether we have an orgasm or not, and finally, it is not the sum of our erotic life.
- This can be part of our sexuality, but it doesn’t have to be.

- Sexuality encompasses what drives us to search for love, warmth, and intimacy. It is expressed in the way we feel, move, touch and are touched.
- This is as much about being sensual as it is about being sexual.

The examination of this documents demonstrates the possibilities of reform and non-punitive models of disability and sexuality. The *Guideline* was revolutionary in positioning sexuality and its various meanings in the lives of those living with disabilities. The framework had also initiated the legal work necessary for staff to help their client(s) with their sexuality without judgement or fear. For example, laws regarding sexual abuse were addressed in the National Board of Services report. The result being collective statements from both the Attorney General and the Ministry of Justice confirming that sexual education that assists individuals with disabilities with sexual training (either physical assistance or demonstration), would not be committing criminal acts (Kulick & Rydström, 2015). This becomes pivotal in the course work later developed for social workers and other professionals eager to learn about sexuality and assisting their clients accordingly, which we will explore later in this chapter.

The *Guideline* and its principles are very extensive within the variety of topics that may arise while supporting sexual citizenship for individuals with disabilities, regardless of disability. The *Guideline* begins by considering the variety of disabilities that alter sexual expression, and how assistants can help support the individual (National Board of Social Affairs, Denmark, 1989). At the beginning of this chapter, I explored the medicalized history of disability in Denmark and its structural violence toward individuals living with disabilities. Throughout, I have demonstrated several movements within Denmark's social policy that took place by challenging current structural barriers, disadvantages, and cruelty to those with a disability. It is crucial to focus on the changes that have been made within policy that once governed the sterilization of individuals living with disability, and fifty years later, recognizing the importance of sexuality and status of sexual citizenship.

In chapter two of the *Guide*, “*Life Stages and Sexuality*” considers the sexuality of individuals with disabilities in different life stages. Take for example the sexuality of adolescents, and their experiences during puberty;

Many young people are insecure and do not know much about their own sexuality. The young people therefore need to talk to other young people, their parents or other adults about their feelings, experiences, and insecurities. For some young people, it is difficult to talk to their parents about the thoughts and feelings they have about sexuality, and they therefore have a great need for a community with other young people, where they can exchange thoughts and experiences” (National Board of Social Affairs, Denmark, P. 3).

Often adolescents living with disabilities have their sexuality ignore and denied. This is frequent within the education system, removing the child from the sexual education class who has a disability as it is believed that the class does not apply to them. Another example is within secondary school and sexual education. Sexual health education is taught through the physical education class, where individuals with various disabilities are not participants. These are current structural barriers and disadvantages to individuals with disabilities that reproduces the discourses to sexuality and disability.

Frequently, individuals living with disabilities struggle for the recognition of their sexuality or have been ridiculed and disciplined for expressing any form of sexuality. Chapter three of the *Guideline* examines how to create a positive environment on sexuality addressing the importance of respecting a client’s privacy while also ensuring a positive open dialogue. Moreover, the chapter continues to advise its reader that workers will not reject the individual’s questions or concerns that arise around love, sexuality, and relationships. Offering suggestions to workers on how to be better equipped to handle such matters ethically and legally.

Chapter four of the *Guideline*, “*Support and help with Sexuality*”, discusses the diverse needs of individuals with disability and their desire to connect with their sexuality may also be diverse in nature. It signifies that some individuals will have lived thus far without the need of assistance, while others may need intensive support to ensure they can exercise their sexuality,

safely, and ethically (National Board of Social Affairs, 1989). Chapter four is extensive in the various ways that support will be administered to individuals who wish to have guidance with their sexuality. Under sub-section 4.2 *Sexual Education*, the *Guideline* supports vary from simply listening to one's concerns around love and sexuality, information on contraception, guidance on masturbation, intercourse, and instructions on how to compensate for barriers that may affect one's attainment for love and a sex live.

Finally, the last portion of the *Guideline* I would like to draw on is sub-section 4.3, "*Other Support for Sexuality*." Here, the document highlights that some individuals need more of a hands-on approach, rather than just verbal advice or instructions. This could entail, as the *Guideline* suggests, help with becoming more outgoing, such that the possibility of meeting a partner is greater. Perhaps an individual needs more physical contact where the helper can contact a sex worker, accompany them to the sex worker, and in some cases speak with the sex worker to ensure individual needs, desires, and enough time is allotted during times of connection (National Board of Social Affairs, , 1989). The *Guideline*'s fundamental belief, shared by the key players presented in this chapter, is that disabled people must have the opportunity to express and experience their sexuality. This document also illustrates the recognition of the lives of people living with disability, to live similar lives like other citizens, with the same rights and opportunity to have sexual citizenship. Throughout this chapter I have explored this movement of recognition since its infancy and the development of Acts and Guidelines that support, assist, and education individuals with disabilities and their rights to explore their sexuality. How do helpers know how to support, assist, and educate their clients on sexuality?

Certified Sexuality

Regardless of disability, it is important for individuals to be educated and supported with their questions, concerns, and expressions of sexuality. As discussed earlier, the Attorney General and Ministry of Justice declared that the assistance of physical or sexual training for individuals

with disabilities was not a criminal act. This became an area of significance that led to the development of a certification program designed for social workers and professionals working with individuals with disabilities, eager to learn how to take part in issues with regards to their sexuality (Kulick & Rydström, 2015).

We have explored various discourses on both disability and sexuality, beginning with the medicalization- and confinement-based approaches to the sexuality of disabled people. Together, they are often ridiculed, ignored, and denied. Silence on these subjects reproduces these discourses. Personal assistants, staff, and other health care professionals need to be open to this discussion, even if the individual does not ask, or cannot ask, is immobile or not. The course that designates certification for such discussions and support was developed in 1990.

Together, both Løt and Buttenschøn, a well-established sexual rights activist, established the sexual advisor certification course, that would forever change the support individuals with disabilities receive regarding their sexuality (Kulick & Rydrström, 2015). The sexual advisor course requires an additional year and a half of study, past the requirements for the already established social work degree program. Its focus primarily on disability and sexuality (2015). During this period, students will read informative materials regarding disability, and implement various projects in their place of employment, analyzed in later group work (Kulick & Rydrström, 2015). The sexual advisor certification course provides skills to advisors, assisting their clients with their sexual needs, alongside the staff, and residents within public and private spaces. This can be done by providing education, information, for disabled partners orchestrating arrangements for sexual activity, assist those who wish to connect with a sex worker, and assist individuals to pleasure themselves who may not be able to themselves (Kulick & Rydrström, 2015). This does not mean that a helper can be ordered to assist in the sexual assistance of their client. Rather, they are compelled to seek assistance, so the individual receives their desired needs. Here, it is important to note that the rules, regulations, and duties of the sexual advisor

align with the Guidelines framework of providing individuals with disabilities the opportunity and possibilities to attaining a sexual life. The Guideline and the sexual advisor certification program, work harmoniously together providing the professional and ethical framework for their profession (Kulick & Rydrström, 2015).

There are close to four hundred sexual advisors who have their certification in Denmark, as of 2015. Moreover, two more certification programs have been developed in Copenhagen and Odense (Kulick & Rydrström, 2015). Throughout this chapter we have discussed various changes to policy for disability and sexuality in Denmark. We noted the similar history of institutionalization and medicalization in that country, as experienced in Canada. In this light, it is remarkable to comprehend how this movement has flourished so intensely that there are two additional diploma programs due to the high number of social workers who want to become a certified sexual advisor. The compassion and recognition for individuals with disabilities and their sexuality is widespread. As one sexual advisor states,

If you have the understanding and the education and you know how important it is to be able to experience one's sexuality, as a person, then you work out the boundaries. You aren't their sexual partner, you're not there to satisfy them sexually. Your job is to help them have sex if they want help" (Jeanette Bramming as cited in Kulick & Rydrström, 2015:119).

Denmark has made significant changes within policy and practice to ensure that individuals with disabilities have full potential of learning and exploring their sexuality. The development of the sexual advisor certification program, along with the *Guideline* reinforces the normalcy of sexuality and its significance to one's identity. As demonstrated throughout their research in Denmark, regardless of the significance of disability their erotic attainment is possible and are able to experience it with integrity (Kulick & Rydrström, 2015).

In the postwar period, Denmark had policy and practices that were once rooted in the medicalization model producing discourses to both disability and sexuality. The medicalized and institutional practices that produces disability as a problem, asexual, sexually deviant, or in need

of intervention and cure. Why do we continue to position disability as a problem? Consider the punishment endured when an individual with disability tried to express or experience their sexuality. Why would we punish a basic need and right, based upon difference? The changes that have been made for individuals with disability in Denmark are by far the first of its kind. Rather than maintaining sexuality as a thing to keep private, secretive, or a thing merely for reproduction, Denmark has positioned sexuality as a public space for discussion. Simultaneously, Denmark has created the same public space for disability.

Bank-Mikkelsen's normalization principle influenced Danish legislature leading to various supports for disability and sexuality that we have explored. These supports have created ground-breaking benefits for individuals with disabilities in Denmark and promoted their sexual citizenship. This includes, for example, having the opportunity to talk about sex, without being punished or ridiculed. Or, being acknowledged as *capable* to have relationships. These benefits, that are taken-for-granted by non-disabled citizens, have finally become the 'norm' for Danes with disabilities. One cannot argue these benefits far out-weigh the once medicalized and institutionalized approach to disability. However, we need to consider whether there are potential costs of such policies.

Although these shifts in political and cultural perspectives are innovative, we must consider the possible implications of state involvement in sexuality. Some might argue that the sex lives of individuals living with disability is not a public matter or concern. In this view, neither the state nor civil citizens should be involved in whether individuals with disabilities should be discussing sexuality, let alone help facilitate sex. Why should the state get involved in the sex lives of individuals with disabilities when they do not for other citizens? Could this potentially reproduce stigma toward disability and sexuality? It is important to consider these questions for the future of sexual policies being proposed and its intentions. My goal here has

been to trace discursive shifts and the changing institutional landscape in Danish history, whereas the ethical implication of this history is worthy of future study.

This chapter has explored the various discursive shifts of disability and sexuality over the last seventy years in Denmark. Historically, individuals with disabilities were people to avoid, thought of as deviant, and thus segregated from society. Historically, this meant the removal of individuals with disabilities, who were placed into confinement. These exclusions were not just within institutions, exclusions of reproductive rights and forced sterilizations were regulated and controlled by the state. As demonstrated earlier, the challenges to institutional care and practices, led to the dismantling of these institutions and crimes towards individuals with disability. The crucial questioning of institutional care and forced sterilization was the launching force behind these discursive shifts. We noted a fundamental shift, toward the recognition that everyone has the right to express their sexuality, regardless of their physical or mental abilities. This new perspective within social policy, led to the development of the certified sexual advisor program, and a new ethic of sexual education. These discursive shifts tell us that disability is *not* a problem to fix, cure, or a reason to deny one's citizenship. Disability is not in need of segregation and isolation. Disability is not asexual or sexuality deviant. Disability, as Bank-Mikkelsen envisioned, became empowered through normalization principles. Here, I ask, can we (in popular culture, in medicine, within policy and legislation) use this same framework to seek the same potential shifts in Canadian policy?

Like Denmark, Canada has historically positioned disability as a medicalized problem in need of a cure, and has employed segregation, and institutional isolation. Canada also shares the eugenic history and policy seen above. Yet, while experiencing the same discursive shifts, a repressive discourse on disability and sexuality remains in place in Canadian policy. How can we confront or challenge it? How can individuals with disabilities in Canada experience the same recognition and acknowledgement for sexuality? We (in popular culture, in medicine, within

policy and legislation) have yet to recognize or acknowledge disability and sexuality within our frameworks as Denmark has. Here, I will turn my focus to the discursive shifts for disability within Canada. I will first explore the Canadian history of disability and institutional care. Next, I will examine policy and legislature within political and social structures. Finally, I will demonstrate the current political and cultural positioning of disability and sexuality in Canada and what justifications, if any, for their exclusion within policy.

Chapter 4

Canada: Legacy of Colonial Power

To better understand the present relationship between disability and sexuality in contemporary Canadian policy, it is crucial that we investigate its history. As seen in the Danish example, repressive discourses continue to divide disability and sexuality, keeping them pathologized and institutionalized. Here we must also consider structural violence toward other populations such as Canadian Indigenous, LGBTQ+, and BIPOC to the present day. A history shared within these groups show that individuals with disabilities were ridiculed, isolated, segregated, and institutionalized throughout the nation-state. These groups, like disabled people, were positioned as deviant, abnormal and a danger to society (Fritsch et al., 2022).

As discussed in the previous chapter, Denmark's political and social systems were once dominated by a medicalized lens to disability. This was followed by the examination of the discursive shifts that took place over the last seventy years and its impacts on individuals with disability and sexuality. I cannot examine the complete historical production of policy and disability in Canada. I will, however, focus on two Federal policies that shape disability and sexuality to this day, and represent the institutionalization of pathological discourse. First, I will explore the 1910 Canadian Immigration Act and its policy on individuals with disability, along with the Sterilization Act of 1928. I will then draw on the work of Fritsch (2016) by exploring the historical ableism embedded in Canadian social structures, then Titchkosky (2007) who demonstrates recent developments in policy that reproduces the discourses we have discussed throughout this project. Finally, I will discuss these current policy and practices within Canada and discuss why individuals with disabilities are limited in their status of citizenship.

Colonial Biopolitics:

Throughout this project, I have examined the political and cultural construction of disability and its discourses. Here, I look to their history within Canada. First, we must explore how disability was understood as a medicalized problem in need of institutional care, and how it structured these discourses. This chapter will focus on the historical construction of disability within Canada focusing on policy discourse. My first example will focus on settlement and immigration policies and practices in Canada, that have constructed disability as a threat to society. It is critical to examine these past injustices within Canadian policy framework regarding disability, to ensure that current policy and practices do not continue to perpetuate discourses to disability and citizenship.

At the time of settlement, with the French and British colonizing Canada, Indigenous people were viewed as a problem, something to fear (Hansen et al., 2018). Here, the race and culture of the Indigenous communities were constructed as deviant and inferior to the dominant class. This led to the isolation, segregation, and assimilation of Indigenous people. These colonial ideologies led to sterilization policies and practices (Hansen et al., 2018). While the focus of this project is on disability, it is important to acknowledge the acts of the colonial powers and their discriminatory policy and practices.

Colonial power had detrimental impacts on Indigenous populations and continues to do so today. Settler colonialism enforced isolation, segregation, and government sanctions, formed the structural violence Indigenous communities have experienced over generations (Tuhiwai Smith, 2021). These dangerous discourses have led to current stigma, discrimination, and structural disadvantages experienced by Indigenous populations experience. Prior to settlement, although very little research has been documented, Indigenous communities embraced differences among sex, sexuality, and disability (Robinson, 2019; Kapp, 2012). Autism, for example, was seen as a beautiful difference (Kapp, 2012). In fact, individuals with disabilities were viewed as gifted, with the ability to connect themselves and community to the spirit world (Rice et al.,

2021). Here, it is crucial to note in current research, First Nations children with autism are not only underrepresented within current Canadian data, but autism is also under-detected (Lindblom, 2014). Lindblom suggests the reasoning behind this discourse of First Nations children with autism, is due to the historical colonial violence that continues to perpetuate racism and stigma within policy and social structures (2014). Thus, the colonial exclusion of Indigenous people and culture also bears on disability, and sexuality.

Like Denmark, Canada has viewed disability through a medicalized and pathologized lens. Beginning with the settlement of North America, disability was produced as a problem, the *thing* that society should fear, avoid, and eradicate. Autism politics in Canada are deeply colonial. Negative stereotypes about patient deviance, specifically within the health care system, bestow inaccurate and/or delay of a diagnosis of autism (Lindblom, 2014). Moreover, Lindblom demonstrates the medicalized tools to diagnose autism, the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), based on western-medicalized model is not pertinent to Indigenous populations (2014). Heritage and culture are not considered within medical diagnosis process and cultural factors and perspectives can affect the ways in which autism displays itself (2014). Despite the calls to action driven by the *Truth and Reconciliation Commission* (2015), there remains exclusionary practices within policy and practices that continues to marginalize and oppress Indigenous people. In fact, Canadian practices and policies have historical roots of discrimination toward those who were a threat to the dominant white settlers, those who differ in race, ethnicity, and ability. Race and disability become a visible threat to Canadian society. They become two categories of difference, labels to be aware of, to avoid, and to ensure are segregated from the rest of society.

We can see disability, sexuality, and settler colonialism at work in immigration history. Immigration policies are an important site of colonial biopolitics, with the influx of immigrants in the early 1900's, and hundreds of newcomers entering Canadian ports. Canadian settlers were

faced with a new social threat, those immigrating individuals (Asian and African) who were not deemed white *enough* and did not speak French or English (Hansen et al., 2018; Li, 2001). In fact, these visible differences led to the construction of who was considered lower status or less human value than those who were already established in North America (Hansen et al., 2018). Often, immigrants were visibly malnourished, ridden with sickness and soiled, leading to the formulation of low identity status (ibid). Moreover, as many individuals could not speak English or French, their identity was presumed to be biologically/genetically feebleminded or criminal unfit to live amongst society.

With new immigrating populations, came new metrics to analyze them. At the beginning of the nineteenth century, Europeans began with the medical use of statistics to conceptualize who was within the 'norm' of intellectual measurements (Hansen et al., 2018). Categories were created to determine the scale or percentage of one's intellectual level, and who would be deemed as a productive citizen or not. And so, with these statistical tests, medical teams could scientifically determine who was going to be a burden, delinquent, or a non-productive citizen, in need of institutional 'care.' During the period of 1850-1970, institutions began to surface throughout Canada, with the intentions to isolate and confine individuals deemed to be 'feebleminded' or 'mentally deficient' and protect the purity of the Canadian population.

Following Foucault's (1990) conception of biopolitics, immigration policies aimed to control the population and its potential citizens. Not only were targeted individuals deemed unsuitable for Canadian society, but they were also deemed inadequate to procreate. Therefore, the formulation of strict immigration laws was formulated, along with the practice and policy of sterilization. Later in this chapter, I will examine the Immigration Act of 1869, whereby individuals with disabilities were excluded and prevented to immigrate into Canada. Additionally, I will explore further the Sterilization Act that both institutionalized and sterilized those living with disability and other populations who were considered social threats.

Birthplace of Institutions and Biopolitical Practices:

The use of medical instruments and testing of such individual became imperative to find solutions to these problematic individuals. This medicalized approach sought to prove biological determinants of socially inept behaviour, elucidating consequence of lower biological qualities (Hansen et al., 2018). Therefore, if medical and scientific tests determine the biological inferiority of one's genes, these problematic individuals must be eliminated from reproducing their menial genetics into society. These ideologies construct disability as undesirable embodiment, a body to fear, a body that is unnatural, a body to avoid at all costs.

We find a further example of colonial biopolitics in the 1869 *Immigration Act*, whereby individuals with disabilities were defined as the defective class. Within this act, it was up to the Medical Superintendent to determine who was defective or fit enough to be admissible into Canada (Statutes of Canada, 1869). In the section under Special Duty of Quarantine Officers,

If on examination there is found among such passengers any Lunatic, Idiomatic, Deaf and Dumb, Blind or Infirm Persons...in the opinion of the Medical Superintendent, likely to become permanently public charge, the Medical Superintendent shall forthwith report the same to the Collector of Customs at the Port at which the Vessel is to be first entered....a Bond to Her Majesty in the sum of three hundred for every such Passenger so specially reported (p.36)

Over forty years later—and—the 1910 *Immigration Act* demonstrates the continuity of ableist biopolitics. Chapter twenty-seven, subsection three, *Prohibited Classes* reads:

No immigrant, passenger, or other person, unless he is a Canadian citizen, or has Canadian domicile, shall be permitted to land in Canada, or in the case of having landed in or entered Canada shall be permitted to remain in therein, who belongs to any of the following classes, hereinafter called 'prohibited classes',

- A. Idiots, imbecile, feeble-minded persons, epileptics, insane persons, and persons who have been-insane within five years pervious; (p. 4).

Undesirables were tossed aside to space of confinement, comprised of asylums, prisons, residential schools, group homes, sanatoriums, long-term care, and psychiatric institutions (Fritsch et al., 2022). Common practices within these sites of confinement, were eugenics and forced sterilization. Practices also included the medicalization, imprisonment, and criminalization, often in forms that were dangerous and even deadly to those in their ‘care’ (Fritsch et al., 2022).

The social construction of disability in Canada can be read as a story of heteronormative and colonial exclusion. These hegemonic underpinnings that have created ideologies of what is normal and what is not. Foucauldian (1990) genealogy asks, what bodies are valued, and which ones are not? The historical power relations have shaped our knowledge and understanding of disability and its desirability. Foucauldian genealogy asks us to explore the categories, labels, signs, and symptoms of the abnormal thing we should be aware of, to avoid, to restrain. These violent colonial legacies have shaped our perceptions of what is normal, able, intellect, and desirable (Fritsch et al., 2022). Individuals that do not meet these perceptions, were subjected to exclusionary practices and denial of citizenship.

A biopolitical history of Canada requires an examination of eugenic practices. The roots of these structures formed through colonialism, racism, eugenics, and sexual reproductive control (Fritsch et al., 2022). The *Sexual Sterilization Act* was introduced into Canadian policy in 1928 until 1972. Describing such practices from chapter 59 entitled, *An Act*

Where it appears to the Superintendent of any institution within the scope of this Act that any inmate of that institution, if discharged therefrom without being subjected to an operation for sexual sterilization, would be likely to beget or bear children who by reason of inheritance would have a tendency to serious mental disease or mental deficiency, the Superintendent may submit to the Board of Eugenics a recommendation that a surgical operation be performed upon that inmate for sexual sterilization.” (Canada, 1933: 200).

These are two examples of the policies that have discriminated against individuals with disabilities throughout Canadian history, limiting and restricting their access to citizenship. Producing disability as defective, and disabled people as a prohibited class and inadmissible to citizenship within Canada, I will argue, is ableist. Since its infancy, little change has been made

within immigration policy that values individuals with disability. In fact, there is a historical tendency in Canada that continues to limit and restrict individuals with disability as citizens.

Alongside the 1934 Forced Sterilization Act in Denmark, these Canadian Acts clearly demonstrate that both states were determined to eliminate the potential reproduction of the unfit. Both states insisted on the segregation, isolation, and elimination of disability. Canada's long history of institutionalization was positioned as intervention or rehabilitation, however, there was never the intention to cure or heal. The goal was to imprison those who could not conform to social norms (Fritsch et al., 2022). Institutional *care*, it has been documented, commonly consisted of being overcrowded, residents having to shower amongst each other, individuals being locked in cage-cots, given experimental drugs, or being fixed into straight jackets (Fritsch et al., 2022). In Canada, it was state policy, in terms of disability, that individuals be institutionalized as they were unable or unfit to be productive citizens (Fritsch et al., 2022). Those deemed unfit were cast away.

By the mid-twentieth century, the increase in Canada's population led to an increase in institutions. The existence of normalizing institutions was politically and culturally justified to manage those causing social ills. They were also justified due to the economic resources it provided for the non-disabled population (Hansen et al., 2018). It is important to note that many residents of these spaces, were economically exploited. There have been reports of inmate labour within the institutions, but also labour to the external economy (Hansen et al., 2018). 'Inmates' were also forced to work in various conditions, within various community industries, without pay. It is important to note here, that many of the same businesses currently rely on low-wage disabled workers with support from incentives and government grants (Hansen et al., 2018).

By the 1960s-1980s technology has made significant developments for individuals with mobility impairments, particularly following the polio epidemic and World War II. Although advancements were made with prosthetics, wheelchairs (allowing for mobility), and ventilators (for better air flow to the lungs), individuals with disabilities began to realize how society was

built around them, not with them (Hansen et al., 2018). Individuals with disabilities were beginning to speak out about having control of their own lives. This led to, for example, the formation of the Manitoba League of the Physically Handicapped (ibid). Members were tired of medical teams predicting their fate and being excluded from the economic and social life that non-disabled citizen had in Canada (Hansen et al., 2018). Here, individuals living with disabilities began to demand their rights as equal citizens. The disability rights movement soared during this time, resulting in significant changes to legislature in Canada. Their achievements included the call for deinstitutionalization, repealing of the *Sterilization Act*, implementing the Developmental Services Act, and the passing of the Canadian Human Rights Act, to name a few.

While the Canadian government began deinstitutionalization around the 1960s, individuals with disabilities encountered further barriers. The shift from institutions to private care, for example, led to other forms of confinement. With few residential spaces available, disabled individuals were forced to reside in jails, prisons, psychiatric facilities, and group homes (Fritsch et al., 2022). As institutional care was challenged, private solutions reproduced the isolation and segregation of individuals with disabilities.

Education represents another site of colonial biopolitics, linking the control of disability and sexuality. Here, I will draw on the work of Jay Dolmage exploring the practice of eugenics and its construction of how North Americans viewed the body and mind (2017). Dolmage shows that higher education was built on biopolitics in a literal manner. Throughout their recent history, academic basements housed laboratories performing the biological and social experimentations described above (2017). Institutions for ‘feeble minded’ children, children’s psychiatric institutes and Indian residential schools were used as laboratories where researchers, doctors and scientists would perform experiments (Dolmage, 2017). Through these eugenic practices, scholars were determining the fate of others, deemed dispensable via racist and ableist ideologies (2017).

Born as part of Canadian institutions, the eugenic gaze aimed to manage problematic social groups. Institutions became a solution to house individuals with disabilities to protect the public from their deviant behaviors. These institutions were dubbed as establishments for *therapy* for the insane, deaf, dumb, deviant, and feeble-minded. Residents experienced horrible living conditions, subject to cruelty and degrading situations (Hansen et al., 2018). Moreover, educational institutions were created that ‘specialized’ in the care of the disorder/disability. For examples, consider the Ontario Institution for the Education of the Blind, the Ontario Institution for the Education of the Deaf and Dumb, the Manitoba Institute for the Deaf and Dumb, and the Victoria Industrial School. These institutions were established to shape individuals into ‘good’ citizens who would not be dependent on state funding or burdens to their families (Hansen et al., 2018). Here, we can see that individuals with disabilities, along with other marginalized groups, were culturally viewed as problematic, as poor or unwanted citizens.

The discourse to disability and citizenship has been long throughout Canadian history. Although many changes within social policy have been developed in the name of equal citizenship, othering discourses continue to be reproduced. So far, I have been talking about the birth of institutions and the treatment of individuals with disabilities in colonial Canada. Here, I will discuss how institutions exist today. I will turn to the work of Titchkosky, examining a key government document set to conceptualize what disability is in Canadian society.

Institutions as They are Today

We find the legacy of colonial biopolitics in contemporary disability policy. Here, I will draw on Titchkosky’s (2007) examination of *In Unison 2000: Persons with Disabilities in Canada* document, and its text that aims toward full participation of citizens with disabilities. *In Unison 2000*, produced by the Canadian government, is said to set the stage for new national understanding regarding issues on disability. Titchkosky (2007) demonstrates that the framing of disability throughout the text of this document, is one where disability is a thing to be tallied, a thing that is

in possession of, a reproduction of disability as a problem. The introduction of *In Unison 2000* displays a ‘facts and figures’ table regarding disability. Each bullet point illustrates the per cent of how many Canadians have a disability, how many of which are categorized by gender, age, severity, Indigeneity, socio-economic status, race, education, and most importantly the prediction that the numerical problem of disability will only increase (p.5). Here, as Titchkosky points out, Canadian documents produce disability as misfortune, and these ‘facts’ continue to be circulated time and time again for anyone interested in its candor (2007). Regardless of the various intersections of disability, the *fact* is, individuals with disabilities are not full citizens participating in Canadian society.

Titchkosky demonstrates disability as problematic using the first bullet-point-fact within *In Unison’s* introductory figures. “In 1999, 16 per cent of Canadians were considered to have a disability. That is 4.2 million people – 3.9 million living in the community, and 273,000 in institutions” (p.5). Here, disability becomes a calculated problem located among citizens living in Canada. Disability is a problem condition that resides within various communities, and certain bodies are affected by ‘it’. Here, we must consider the data collected to produce these statistics. The various categories or labels that limit or restricts the body as fully-functioning, the medicalized lens that produced these staggering numbers. Policy here, rooted in the medicalization of disability, produces disability as a problem. And, the problem of disability lies in the individual, its body, or within its mind.

In Unison 2000 states, “Every person with a disability faces a unique situation, determined by a variety of factors including the nature of their disability, their family situation and their community, as well as their cultural context – an important consideration in a multicultural society” (p.6). Here, disability and its unique (problematic) situation, stem from the *nature* of that disability, the body that hosts it, its family, and surroundings. Not the historical, political, and cultural production that has created the *unique situation* that every person with disability faces. Another

excerpt states, “Those who live in northern, rural and remote communities – of which a high proportion are Aboriginal people – face special challenges that differ from resident of urban southern Canada....” (p.6). The colonial legacy, the development of the Indian reservations and residential school systems, whose very purpose to isolate, degrade, and eradicate Indigenous people may have something to do with the unequal accessibility of support and services. Considerations of disability are given a position; disability is problematic of the individual. What is not considered here, is how disability has been historically produced to be defined as a problem, in need of institutionalization.

Titchkosky looks at *In Unison 2000*, in the context of a Canadian society that is to improve the lives of individuals with disabilities. The neoliberal shift has drastically altered the social policy landscape. Titchkosky points out that Canadian policy continues to present disability as a problem; the problem of disability as the abled-disabled citizen (2007). Like Titchkosky, I will show how current policy continues to categorize disability as a problem. Given social policy is largely a provincial matter, I will draw the Ontario Disability Support Program (ODSP), and its inclusion/exclusion of the abled-disabled body.

Neoliberal welfare reforms are guided by an ethos of market-based productivity and characterize social policy in Ontario and Canada as a whole. In short, to be a good citizen, is to be a contributing citizen. Welfare reforms related to disability continue to be based upon the medical model to determine who is the ‘able-disabled’, and who is not (Smith-Carrier et al., 2017; Titchkosky 2007). Launched in 1998, the ODSP was put in place to support and protect individuals with disabilities (Smith-Carrier et al., 2017). The benefit was established to support individuals with disabilities to become independent and employable (Smith-Carrier et al.,).

To be eligible to receive ODSP benefits, you must meet strict criteria of having a significant physical or mental impairment that is expected to last more than 12 months and effects one’s ability for employment (Smith-Carrier et al., 2017). Benefits hinge on whether one is

severe-enough, disabled-enough, employable, or non-employable for state assistance. In this way, the provincial government determines who is biological or pathologically limited, flawed, and unable. Moreover, the ODSP encourages its recipients to work, and provides Employment Supports. However, past this, the program does not consider the barriers some individuals with disabilities may face while trying to gain employment. And again, the difference in able-disabled bodies will determine who can achieve employment and who cannot.

Neoliberal practices use individualistic economic productivity to consider who is a worthy citizen and who is not, we find that disabled people do not fit into their vision of society, as Capurri (2018) notes. With the move to the neoliberal governance of disability, and its interest in cost-saving, the need has increased for services and supports that are provided through organizations, while simultaneously, these services have undergone funding cuts (Chouinard & Crooks 2008). In the aim of cost saving, social assistance rates have dwindled relative to the cost of living, and eligibility criteria are strictly policed. In these market-based, individualistic solutions we govern disability from afar, ultimately creating a system that is inadequately meeting the demands of people with disabilities. Here, it is important to state that these practices and its governance continue to perpetuate the discourses for disability.

Looking through the institutional history of Canada, disability remains to be seen as an individual problem, rather than recognized as culturally and politically organized outcome. Throughout this chapter I have demonstrated the various disadvantages and barriers that have been within Canadian landscape of disability. These institutions continue to perpetuate the exclusion of individuals with disabilities as citizens within society today, born of the colonial institutions described in this chapter. What characteristics or attributes does one need to be considered a participating citizen? What factors determine who is deserving of being labelled a citizen and who is not? What does having full citizenship entail? Here, I will shift focus to the current repressive dealings of disability, sexual politics, and citizenship.

Disability and Sexual Politics:

This project is guided by a single question: why is there discomfort in discussing disability and sexuality in Western culture? As sociologists, we must ask: how does this manifest institutionally? While I explored the shifts that drastically changed the landscape of disability in Denmark, I wonder why Canadian politics have not followed suit. Why does our social service system choose not to recognize the relationship between disability and sexuality? Should sexuality not be included within our social and civil rights as human beings? Here, I will discuss the systemic repressions that continue to impede on individuals with disabilities and their status as sexual citizens.

The medicalization of the body, as I have demonstrated, constructs disability as a thing to prevent, to avoid, and eradicate at any cost. The isolation, segregation, and discriminatory practices rooted in colonial biopolitics, unfortunately, still exist today. Discriminatory policies continue to oppress and marginalize individuals with disabilities. Historically, individuals within these institutions were not exposed to relationships, nor was sex ever an option (Shakespeare, 2000). In fact, as discussed earlier in chapter two, harsh-punitive measures were taken if one *did* express their sexuality or desires (Kulick & Rydström, 2015). Systemically, individuals with disabilities have and are devalued.

In what follows I will suggest it is crucial to recognize these systemic repressions and the impacts. The political, cultural, and social construction of disability has led to the stigma that individuals with disability are asexual (Siebers, 2001; Titchkosky, 2007; Kulick & Ryström, 2015). Although sex and disability are not a new topic of discussion, it is however, often neglected within disability rights discourse (Shakespeare, 2000). As I illustrated drawing on the work of Titchkosky, disability integration in Canada is based on *support, employment, and*

income (2007). What about relationships? Should relationships and sex not be considered part of participating as full citizens within society?

The sexuality of disabled people has long been oppressed, controlled and surveilled institutionally. We have seen this in both Denmark and Canada, structural violence continues today by the lack of access to sexual education, lack of assistance who will discuss sexuality, and the lack of disability and sexuality in pedagogy for those interested in working as assistants (Earle, 1999; Sanders, 2007). In what ways can we challenge these practices?

The Western idea of sex or sexuality, as discussed in chapter one, is heteronormative. Sex and ability exist together, ability makes for the foundation of sexual activity. Sexuality is identified for and by the able-bodied, to reproduce ability. Here, I will argue sexual identity for individuals with disabilities has been constructed as a minority identity. An identity some wish to explore, but how? As Shakespeare (2000) points out, many individuals with disabilities seek the approach of normalization. That is, for disabled people to have access to sexual identity and sexual expression as their able-bodied counterparts. I point out critically that individuals with disabilities have exclusively been repressed of their sexuality. The reality for Canadians with disabilities, past and present, has been exclusion from society, exclusion of reproduction, exclusion as sexual citizens. So, how do we (in popular culture, in medicine, within policy and legislation) talk about sex? Or how do we talk about sex and disability without discomfort?

Tobin Siebers:

First, we must return to the disability literature on sexuality. Siebers explores the basis of a sexual culture for disabled people. Sex and disability are not a new area of contested discourse for disabled people. As Siebers (2011) demonstrates, disabled people, like other sexual minorities, have a history of sexual suppression, limiting their sexual agency. Here, it is the sexual identity of disabled people, that has been politicized and constructed as a sexual minority. Sexual identity, the thought of having a sex life, and *who* can have a sex life, has been based upon

what Siebers calls the ‘ideology of ability’ (ibid). This rendering of sexuality has warped our attitudes and understandings altogether, the ideology determines who can and cannot have a sex life.

Siebers’ sexual culture for disabled people means treating disabled bodies through a new erotic imagination. Disabled bodies are not problematic and like the fight for social and civil citizenship, here, *sexual* citizenship is just as important. The breaking down of barriers, de-medicalizing and deinstitutionalizing current restrictions to sexuality is a must. The role of sexuality and identity co-exist and exist in people with disabilities. However, recognizing that they exist is crucial for the futurity of disability as sexual citizens.

Sanders:

Sexual and structural barriers restrict disabled people within the environments where they may build upon relationships, express themselves openly regarding sexuality, or access to opportunity to have sex (Sanders, 2007). Here, as Sanders (2007) demonstrates, we continue to discuss sex and sexuality from a traditional position based on reproduction. This traditional way of thinking tells us that we do not need to talk about sex with disabled people, nor should they express any interest in doing so. How do we address future goals of relationships and sexuality when they are currently being ignored? How does this affect the futurity of disability and sexuality? These questions raised regarding the training and knowledge of the worker that support individuals with disabilities regarding sexuality. Individuals with disabilities want to have sex. They want to know how, with whom, and often ask ‘why can’t I?’ (Shakespeare, 2001; East and Orchard, 2014). What is preventing them?

East and Orchard (2014) illustrate the importance for youth to accept and understand the role of sexuality and its significance to positive development of self-image and identity. They express the need for sexual agency through interviews with adolescents with disabilities. They found

many tensions between what they are denied access to because of their disability, including sexual education information and instruction and a complete absence of media or mainstream representations of ‘their’ kind of sexual possibilities, and the normal desires of most people. (East and Orchard, 2014, p.570)

This demonstrates the desire youth have in learning their sexuality, however, they are restricted and/or denied this information. Cultural and social barriers continue to perpetuate punitive discourses for disability and sexuality, against the expressed desires of marginalized people.

Saxe and Flannigan:

Saxe and Flannigan demonstrate adults with disabilities expressed current restrictive policies and lack of support impede their sexual citizenship (2016). For example, those who are living in residential care face a lack of privacy, constant supervision, rules where one cannot lock their bedroom door, and policies that prevent sexual encounters in their own bedroom (ibid). Here, with a relatively recent investigation conducted by Saxe and Flannigan, demonstrates the continuity of restrictions and surveillance that individuals with disabilities encounter.

Moreover, Martino (2019) demonstrates how individuals with intellectual disabilities were not only viewed as child-like in need of protection, but they were also considered to be hypersexual and unable to form an opinion regarding their sexuality. Martino also established workers *chose* not to use their power that could advocate for their clients and their sexual rights. Why do we continue to deny and restrict individuals with disability their sexuality? With a lack of existing, publicly funded material bringing sexual culture to disabled people, Martino’s (2022) lab distributes informative videos and other materials aimed to filling the policy gap. We will return to these kinds of affirmative strategies below.

Saxe and Flannigan’s (2016) work on Canadian support workers suggests that the negative attitudes toward disability and sexuality are due to lack of education. The lack of training specifically toward sexuality was identified as the most instrumental to support workers and their difficulty talking about sex with their clients (ibid). This lack of training negatively impacts the clients by not receiving sexual education that they desire and need. If there is no

sexual training for support workers, how can they truly *support* their client's needs? If there is no discussion on sexuality and disability, how do we (in popular culture, in medicine, within policy and legislation) rid the attitudinal beliefs of sexual deviance or asexual stigmas? Thus far, I have explored the historical view of disability and sexuality through their institutional separation. Now I turn to contemporary discourses of disability and sexuality today.

Disability and Sexuality Now:

This project has explored the medicalization of sex and disability, the institutionalization of disability, the practice of eugenics, and the discourses of disability and sexuality as either deviant or asexual. Although disability rights movements have made gains within social and civil citizenship for individuals with disabilities, we remain stagnant in the development of sexual citizenship. For full participation as Canadian citizens, individuals with disabilities must have the right to express their sexuality, receive sexual education, and access to the opportunity to have sexual relations.

While we read about disability, sexuality, and our children, it is crucial to point out the current focus remains mostly in parents. The provincial government of Ontario published a guide for parents on sexuality and developmental disabilities. *Sexuality and Developmental Disability: a Guide for Parents* (2021) explains to parents that their children will be curious about sexuality, the importance to teach them about their bodies. The guide emphasizes how vital it is that disabled children know masturbating is *ok* but wrong if it is done in public, and 'sadly', people with disabilities are at a higher risk of being sexually abused because they are vulnerable (2021). The guide's discussion of sexuality aims to keep the individual safe, it is not about discussing the potential partnership or sex life one might have. For example, the guide states within its *For Parents and Caregiver* section,

Some people think that if a child or adolescent with special needs is given information about sex and sexuality, it will then increase sexual interest. However, in most cases education is vital to help these children and youth understand their own bodies and

feelings associated with sex and sexuality, and can save a child from embarrassment, humiliation and exploitation (2021).

Here, sexuality is a problem that needs to be avoided. Education regarding sex and sexuality will spare the child from being mortified, disgraced, or hurt. Informative sexual education is feared to increase sexual curiosities of the disabled child or adolescent. These examples from the Ontario provincial guideline demonstrates how sexuality and disability should *not* be read or written about. Additionally, this demonstrates the ways in which colonial and institutional practices and ideologies of disability and sexuality remain in our landscapes manifesting this sexual policy.

How we write and read about disability and sexuality here, certainly makes the relationship one to be feared and avoided. The guide continues within *The Adolescent & Teen with a Developmental Disability*. The document exclaims to parents; ensure that the child understand *appropriate* sexuality, the concepts of consent and privacy, and protect your child. It proceeds to state, that not only should your child understand the particulars around sexual relations, but they should also be aware of other ways to express their sexuality, disease prevention, birth control, condoms, and the responsibility of bearing a child (2021). Not once does the guide mention the possibilities for the child to have intimate relationships or having a sex life. In fact, the guide states, “often parents are embarrassed by their children's curiosity with their genitals, but it is important to avoid harsh reactions” (2021). It is safe to assume by reading this handout, that adolescents with disabilities will be *self-exploratory*, ensure this is done in private and ensure they understand the concept of ‘being alone.’ Here, disability and sexuality are positioned to be explored by oneself, not with the possibility of sharing these experiences with a partner.

Under the heading *Some Facts About Sexuality and Developmental Disability*, the guideline highlights ‘facts’ and statistical findings such as, 32% of males and 83% females are sexually assaulted, children with disabilities are 2.2 times more likely to be sexually abused,

victim rates are ten times higher than non-disabled people. A connection with the work of Titchkosky is easily found in these figures. We read, “although 80% of women and 60% of men with developmental disabilities will be sexually molested by age 18, only 3% of their attackers go to jail” (2021). These facts of sexuality and disability read as a warning that individuals with disabilities as suffering, vulnerable victims-in-waiting. While this document discusses disability and sexuality, we constantly problematize the topic. A discussion about the ways in which sexuality and disability can be achieved is not found. Rather than victimize disabled teens, the *Guide* could use *facts* and *figures* to promote sexually healthy relationships. Although it is important to know that individuals with disabilities may be at risk or more susceptible to being victim, why do we (in popular culture, in medicine, within policy and legislation) continue to pose the *problems* while we discuss sexuality?

The document highlights *What Parents Can Do*, with advice around protection, awareness, and rights from David Hingsburger, of over 20 years’ experience working with developmentally disabled *victims* of sexual abuse or have *victimized* others (2021). Here, disability and sexuality, together, are conditions with negative outcomes or consequences, which the document continues to highlight under the *Tips and Strategies* section that follows. While we continue to discuss disability and sexuality as a problem, we simply reproduce its discourse in sexual policy. We have explored the history of both disability and sexuality. I have demonstrated that within current research the restrictions and surveillance people with disabilities experience while trying to obtain relationships and having a sexual life continues. I have illustrated that although the discussion of sexuality and disability are not new and are being research and discussed, the topic remains one to avoid.

The *Guide* continues, under *Parent Need to Know: The Role of the Parent*, the responsibility to guide their child to become *safe* adults (2021). What does the guide consider to be a safe-disabled adult? One, I imagine, that does not engage in sexual expression or sexual

activity. Throughout this guide, there is an inherent need to instill the fear and danger posed by your disabled child's sexual expression. This remains to be discussed as problematic, the thing that could possibly victimize them, or they in turn become deviant. Words used throughout the document such as, 'appropriate, protect, safe, harm, be aware'; indicate here, that disability and sexuality must be forewarned.

The guide posits disability as a biological and economic loss. Moreover, the concern here is, disabled adolescents should be careful and cautious of sexuality, sexual expressions, and sexual activity. They are not valued or recognized here, to express themselves sexually, to have or be in a relationship, or share intimacy. Why do we continue to devalue disability?

Despite the ableist discourses discussed throughout this chapter, there is a shift in our attitudes and beliefs regarding disability and the status of sexual citizenship, by various scholars, activists, and organizations. Combined, this gives a new platform for people with disabilities to voice their frustrations and express their sexuality. However, what are we really doing about it? A quick google search will demonstrate that there is talk about sex and disability. There are various YouTube videos, pamphlets, quotes from the World Health Organization, among other organizations that say people with disabilities are sexual beings and have a right to have sex.

Organizations such as t6talk, SHORE centre, Love Abilities, Sex with a Difference (SWAD), Talking About Sexuality in Canadian Communities: Supporting Youth with Disabilities (TASCC), and private intimacy coaches. These private organizations all speak of the right to sexuality, the importance sexuality is to disabled people's identity, the possibilities to have sex and the gaps within current education and training.

Various Tedx Talks and YouTube videos are available, highlighting personal and professional discussions on disabled people and sexuality, being in relationships, being disabled and with the LGBTQ2+ community, and attaining status of being sexual citizens. Campaigns such as #UndressingDisability and Amaze Org. Both campaigns address that disabled people are

sexual, have relationships and sex lives, however, there are lack of supports to ensure these opportunities can be attained. The #UndressingDisability campaign, through Enhance the UK, has various areas of advocacy for disability and sexuality such as sex education, meeting the sexual needs of individuals who are living in Residence, and ensuring workers are aware that sexual needs of the people they work for should be part of their professional practice (2023).

How we learn about disability is embedded in colonial institutions that have shaped both disability and sexuality as a problem. To change these discourses, we must address the ways in which disability continues to be a medical issue, in need of intervention, or to avoid at all costs. Within our institutions, policy, and pedagogy, there needs to be a shift in our language of how we discuss disability. As discussed previously, the work of Bank-Mikklesen and his year of advocacy for the lives of individuals with disabilities to become as normal as possible, including the recognition of sexual citizens (Kulick & Rydstrom 2015). The changes made within Dane policy, led to disability and sexuality as capable and normal. Here, I ask, how do we (in popular culture, in medicine, within policy and legislation) put this into practice? Is it possible to have non-dangerous discourses of sexuality within Canadian policy? What would this look like?

Interventions are needed to ensure medical teams and practitioners do not act as the sole predictors of individual limitations, restrictions, or destinies. Medical practitioners cannot assume, for example, their paraplegic patient, will no longer have a sex life, or become a parent. One cannot assume that the non-verbal autistic child will not have friends, education, or a normal life. We must be aware that society has made disability into a *condition*. If we were to mirror Denmark and its normalization principle discussed in the previous chapter, perhaps Canadian ideologies and policies too, can change. We must talk about sexuality and disability; its normalcy and existence to make change.

We have found that disabled students do not have access to the same sexual health education as other students (East and Orchard 2014). Sex education within elementary and high

schools should not only be for the able-bodied students. This should be inclusive and mandatory for all students and must include the discussion of individuals with various disabilities experiencing the same scenarios as their able-bodied counterparts. These students are the future of disability and have the right to access the same sex education as anyone else. Everyone should be seen as *capable* to form relationships, attachments, and sexual relations. Why not include media campaigns in sexual education classes that have disabled teens discussing their relationships and/or sex lives? If we do not talk about disability and sexuality, how can we possibly break the stigmas that surround it?

There is a common trope that sex is everywhere. Billboards, television, film, within advertisements, books, pamphlets, and magazines. Sex is out there. That is—of course—if you have access to sex. As Siebers (2011) describes what he coined as ‘sex culture’ of individuals with disabilities, which is about increasing the access of current barriers restricting sexual locations and give rise to sexual rights. Similar to the sexual liberation movements and the sexual minorities within the LGBTQ+ community, who actively sought to have the same sexual rights and freedoms as heterosexual-able-bodied people.

Sex is everywhere, but not for everyone. Despite institutional claims to inclusivity, exclusionary practices are still present. For example, often children and adolescents with disabilities are denied or restricted sexual health education (Treacy et al., 2018). Sexual health education is within curriculum, however, restrictions and barriers for individuals with disabilities are prevalent. Why do we (in popular culture, in medicine, within policy and legislation) restrict youth and adolescents from sexual education? Will they not have the *ability* to experience relationships or sex? Why do we have different expectations for disabled teens? If we are not discussing sexuality and sex education to adolescents with disabilities, what is the futurity of disability and sex? We turn to these questions in the conclusion to this thesis.

Chapter 5

Conclusion

Throughout this thesis, I have discussed the past and present discourses of disability and sexuality, applied in both Danish Canadian culture and policy. What about its future? My hope is to spark new social, cultural, and political discourses. We need alternatives in how we discuss, read, write, and position disability and sexuality. Canada must reformulate current policy that continues to limit and restrict people with disabilities. Disability and sexuality are fully part of life, and we need to affirm this for all. A final question: what should we do, exactly?

Before looking to the future, we must trace our steps thus far. In chapter two, I explored various theories in disability scholarship, to better understand the causes and impact of medicalized discourse, and its alternatives. Here, we established how disability has historically been constructed as a problem. I uncovered, looking to scholarship ranging from McGuire's *work on autism advocacy* to Richardson's sexual citizenship literature, the medicalized and deficit-based discourses on sexuality in the West. This discourse analysis laid the foundation to unpack the examination of disability and sexuality in two different spaces: Denmark and Canada.

Chapter three extended this discussion to sexual rights in Denmark. Throughout this chapter, we explored both historical and current Danish culture, institutions, and policy debates on disability and sexuality. Early twentieth-century Danish policy segregated individuals with disabilities and the practice of eugenics, as established in the 1934 Feeble-minded Measure Act. We discovered the crucial advocacy work of Erik Neil Bank-Mikkelesen. His normalization principles shifted state policy for disabled Danes to this day. This was a story of policy based on a discursive shift, not a single piece of legislation. We found, for example, the 1989 Guidelines About Sexuality – Regardless of Handicap influenced the course work for certification of sexual

advisors, established in 1990. These political and cultural shifts were crucial to contrast to Canada, and our similar historical practices and policies of disability.

In chapter four I looked to the example of Canada, and the legacy of colonial biopolitics in contemporary disability policy. I demonstrated through the examination of Canadian colonial history, that practices and policies established to keep Canada pure remain in force in our management of disabled sexuality. Through the examination of the 1910 *Immigration Act* and the 1928 *Sterilization Act*, it became clear that colonial Canada aimed to eradicate disability at any cost. This discourse on disability has not changed—disability and sexuality remain distinct and opposed in Canadian policy. We found this in the Ontario government's 2021 *Sexuality and Developmental Disability: A Guide for Parents*. The discourse remained intact: it does not recognize or consider individuals with disability and their status of sexual citizens. This policy only results in a fear of sexuality, the avoidance and victimizing of Canadians with disabilities. Moreover, it suggests that individuals with disabilities will explore their sexuality alone, perhaps inappropriately. There is no opportunity for exploring sexuality with an intimate partner.

Change at multiples levels is needed to ensure that we can eradicate deficit-based discourses of disability and sexuality. A shift in our attitudes and beliefs about disability and sexuality must happen, but where does this begin? Parents are told by medical professionals that the limitations and restrictions their child will face are because of their disability. We face the facts, rather than the possibilities. Institutions continue to label disability, regardless of form, as the thing that will produce a dependent identity. Institutional intervention is required to ensure that parents/caregivers are not given false predictions about their un-abled fate. Disabled children and their future success, like those of their abled-bodied counterparts, are not predictable. We do not predict the fate, success, or non-success of 'typically' developing children, so why do we continue to predict the gloom of the disability child? How can families properly support their children if they believe in the hopeless predicted future?

Families must realize that their children, regardless of embodiment, have a future. What that future looks like; is unpredictable. Just as unpredictable as the able-bodied future. Families need to recognize that regardless of disability, their child has the right to their social, civil, and sexual citizenship. They have a right to the same sexual health education, discussions of potential relationships, and potential intimacy. Rather than assuming limitations, embrace alternative ways of predicted futures. The futurity of disability is one that must include status of sexual citizenship. However, to ensure citizenship, there must begin in a shift in the governmentality of disability and sexuality.

First, it is crucial that adjustments be made to support policy, a provincial responsibility. Take the current Ontario Disability Support Program (ODSP), for example. Here we must begin by making it less restrictive in both *who* receives the support, and *how* it is used. Current restrictions and monitoring of individuals receiving ODSP, have no budget for facilitated sex, outside of their basic needs budget. I have argued that sexuality is itself a basic need, not to be overshadowed by food and clothing. Kulick and Rydstrom (2015) remind us that under the Standard Rules on the Equalization of Opportunity for Persons with Disabilities produced by the United Nations, “persons with disabilities must not be denied the opportunity to experience their sexuality, have sexual relationships and experience parenthood” (p. 287). Should this not include intimacy, and accordingly, benefits to support sexual exploration?

Affirming disability and sexuality is a crucial discussion at all levels of government. Past simply focusing on policy and benefits, we must also explore how this translates into Canadian and Provincial curriculum and pedagogy. Youth and adolescents with disabilities must not be excluded from sexual health education classes. I suggest, for example, rather than having sex education as part of ‘physical education curriculum’, it should be made a mandatory course that is part of the core subject needed to obtain an Ontario Secondary School Diploma. If our social

institutions are claiming to promote inclusivity, diversity and equity within our classrooms, then why do we continue to exclude youth and adolescents for sexual health education?

My last suggestion is to allow individuals with disability the opportunity to experience relationships, attachments, and the possibility of a sexual life. Here I suggest an optional sexual health advisory certification course for those who are working with individuals with disability. This would not be limited to those who hold a social worker degree/diploma, or others in the health care sector. This certification course would also be open to parents and family members, administrators of care facilities, and teachers, for example. To promote a discursive shift affirming disability and sexuality, a course geared to specifically address the relationship in a compassionate and professional manner is required. This will allow individuals with disabilities to openly talk with family, friends, teacher, and support workers without the silence and discrimination we have discussed throughout this project. Individuals with disabilities need to be recognized and valued in our attitudes, beliefs, and in our policy frameworks. This recognition is crucial for the status of sexual citizenship.

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