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## Social models of disability and sexual distress

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## Social Models of Disability and Sexual Distress

Meg Barker and Alex Iantaffi

### Introduction

In this chapter we suggest that there is much to be gained from bringing social models of disability into dialogue with current understandings of sexual distress. First, sexologists and sexual health practitioners could benefit hugely from applying the shift from medical to social thinking about disability to the arenas of sexual 'disorders' or 'dysfunctions'. Secondly, it is fruitful for those studying and working with disability to extend social models to include considerations of sex and sexuality, as in some of the more recent, intersectional revisions of these models.

In order to explore the potential of such a dialogue we devote the first half of this chapter to examining how prevailing norms of sex and sexuality position many of us as mentally disordered or dysfunctional, and could therefore be said to actively disorder or disable people in a manner akin to the way in which certain material features and social norms disable certain bodies and sensory and cognitive experiences. We consider how features of the shift from medical to social models of disability can be applied in this area, to the benefit of those who are struggling with sexual distress and in ways which enhance understandings of sex and sexuality more widely. By 'sexual distress' we mean mental distress which occurs specifically around sex, for example feeling anxious about sexual situations or ashamed of sexual desires.

Following this, in the second half of the chapter, we examine the ways in which medicalised understandings of both sex and disability constrain and restrict the sexual experience and expression of disabled people. We draw out the potential benefits of applying social models of disability to this area, building particularly on recent intersectional work to enable a fuller understanding of the ways in which sexuality, disability, and other aspects of identity and experience combine.

In the concluding section of the chapter we weave these strands together to suggest how social, critical and intersectional understandings of sexuality and disability could inform thinking and practice around both these areas.

Before embarking upon this dialogue we will briefly present our own understanding of social models of disability in order to locate ourselves within the broader themes of this book. We regard these models as an explicit critique of - and move away from - conventional medical models of disability which have predominated in professional and popular understandings of disability. These medical models regarded disability as a lack or impairment which limits and constrains everyday life, and is located within the specific individual (e.g. in an area of their body, in their senses, or in their cognitions) (Iantaffi & Mize, forthcoming 2015).

Social models of disability, on the other hand, locate disability in society rather than in the individual. For example, stairs are viewed as disabling, rather than disability residing in the body of a person who uses a wheelchair. Limits on people's capacities to conduct activities that are essential to everyday life are regarded as imposed by structural and systemic barriers. These barriers are part of a social system that constructs some bodies as normal and some as other rather than considering a broad range of bodies and possibilities. This relegates disabled people to the status of lesser citizens due to lack of access (Barton, 1997; Barnes, 2000).

Disability is therefore viewed a by-product of a society which is organized around only certain bodies which are defined as normative, in legislation, education, institutions and popular culture (Oliver, 2004). This means that solutions are focused around societal rather than medical interventions (Oliver, 2009). For example the provision of audio or captions would be seen as providing access to a wider community, rather than addressing a specific individual need (Iantaffi & Mize, forthcoming 2015).

Finally, social models of disability regard everybody as interdependent, rather than locating disabled people as dependent in order to shore up a neoliberal myth of everybody else as independent. Being reliant on a carer for example, is part of a wider system of interdependency which includes the reliance that everybody has on those who produce food, remove refuse and run public transport. Feminist models in particular, have suggested that cultural emphases on health and normativity place bodies with disabilities at the margins because people do not want to be reminded of their interdependency, limitations, pain and mortality. They have also challenged and broadened social models of disability to include embodied experiences (Morris, 1992, 1996; Wendell, 1996.).

To summarise, social models:

- Are critical of normative thinking which creates binaries of people without/with disabilities (normal vs. other).
- Shift understanding of disability from a lack/impairment of specific bodies, to an understanding that a diverse range of bodies exist.
- Shift from locating disabilities within individuals to within society (structural, material and cultural aspects).
- Regard everyone as interdependent - rather than dividing dependent disabled people from independent non-disabled people.

Please note that we recognise that we have not drawn clear distinctions here between social models and postmodern models of disability, but rather we have considered what all of the more critical/social theories have to offer in combination. Towards the end of the chapter we will turn to crip theory and other approaches which are specifically grounded on an intersectional understanding.

### **Disordering sex**

In this section of the chapter we begin by considering how sexual distress - and sex more broadly - is currently conceptualised. Returning to the features of social models of disability (outlined above) we then explore how these apply to supposed sexual disorders and dysfunctions, outlining how an understanding informed by social models of disability would not only benefit those struggling with sexual distress, but has potential value for all of us.

As with disability, the prevailing model of sexual distress has been a medical one, enshrined within the Diagnostic and Statistical Manual (DSM-V, American Psychiatric Association, 2013) and the International Classification of Diseases (ICD-10, World Health Organisation, 1994). In this chapter we focus on the DSM given that this is the more recently updated of the two, and that the ICD generally follows the DSM in its categorisations. Sexual distress is conceptualised in the DSM as a 'sexual and gender disorder', either under the category of 'sexual dysfunction' or 'paraphilic disorder'.

Broadly speaking the 'sexual dysfunctions' delineate dysfunctional from functional sex, and the 'paraphilic disorders' delineate abnormal from normal sex. Anything which risks disrupting the functional, sexual response cycle of desire, arousal and orgasm is deemed a dysfunction. Thus we have categories for lack of desire: 'erectile disorder', 'female orgasmic disorder' and 'delayed ejaculation'. There are also categories of 'premature ejaculation' and 'penetration disorder' which suggest that penis-in-vagina penetration is considered necessary for functional sex to have occurred (Barker, 2011a). Paraphilic disorders are defined as 'intense and persistent sexual interest other than ... in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners', demonstrating that preparatory fondling followed by genital stimulation is regarded as normal sex, and that sexual interest in anything other than this is regarded as paraphilic (unusual or abnormal) sex. This category includes interest in certain sensations and materials, in being watched or watching others, and in mixing sex with pain, physical restraint or power (for more on the history of how such categories developed, see Irvine, 2005; Berry & Barker, forthcoming 2015).

These conceptualizations of sex are not restricted to psychiatric texts and practices, but rather they form the basis of much wider cultural understandings and norms. So, for example, the same divisions of functional/dysfunctional and normal/abnormal sex are replicated in the most popular 'bibles' of sexology used in the training of health practitioners and sex therapists (Barker & Richards, 2013). They are also echoed in mainstream sex advice across self help books, magazine and newspaper problem pages, and TV documentaries. For example, most bestselling sex manuals present a model of sex as: foreplay, followed by penis-in-vagina intercourse, ending in orgasm. Such books consider difficulties with erections, penetrations or orgasm as requiring of correction, whilst 'alternative' sex is relegated to a final chapter of the book with many notes of caution around not straying into anything that the authors regard as abnormal or dangerous (often including 'real' BDSM and fetishes as opposed to light bondage or blindfolding, and also cybersex, or group sex of any kind) (Barker, Gill & Harvey, forthcoming 2015).

People are clearly disordered by these prevailing binary understandings of sexual function/dysfunction and normality/abnormality. The most recent UK survey of sexual attitudes and lifestyles (Natsal-3) for example, found that 42% of men and 51% of women reported having a sexual problem: so around half see themselves as sexually dysfunctional (Mitchell, et al., 2013). Similarly, statistics on the number of people who entertain fantasies of bondage or spanking are usually well over fifty per cent of people (Richards & Barker, 2013) as evidenced by the huge popularity of the *Fifty Shades* series (Barker, 2013b) and yet, sexual sadism and masochism remain on the list of paraphilias. Advocates of such categories point out that under DSM-V, paraphilias are only categorised as disorders if they cause distress or impairment to self or others. However, as with homosexuality - which was only removed from the DSM in 1973 and the ICD in 1992 - the stigma involved with being regarded as potentially disordered is, in itself, a cause of distress. It can easily be argued that the sexual categories of mental disorder are making us crazy (Kutchins & Kirk, 1997).

As with medical models of disability, we can see here that binaries are created of people with and without sexual disorders. 'Normal people' have functional, normal sex, and others have sexual dysfunctions or paraphilic disorders. Interestingly though, in this case, the evidence around dysfunctions and paraphilias make this hard to sustain given that - statistically at least - it is probably far more 'normal' to have a sexual dysfunction and/or paraphilia than it is to not have one.

As with disability, sexual disorders are considered to be a lack or impairment of certain bodies and/or psychologies and are therefore located within the individual, rather than within broader systems, such as heteronormativity. Most treatment involves some form of medical, behavioural or psychological intervention (for example, PDE-5 inhibitors for erectile dysfunction, masturbatory techniques for premature ejaculation or challenging negative thoughts for orgasmic disorder) (Barker, 2011a; Kleinplatz, 2012).

So what could be gained, in this area, from applying the social model of disability? We will now return to each of the main features of social models in turn.

### *Rejecting binaries*

First, we could reject binary models of people with or without dysfunctions and disorders for a model of sexual diversity. Many critical, queer and feminist sexologists have argued for such a shift to what Rubin (1984) terms benign variation, rather than a hierarchical model that keeps attempting to redraw the lines between what is considered good, normal, functional sex, and bad, abnormal, dysfunctional sex. For example, authors such as Irvine (2005) have pointed out how people are pathologised for wanting/having both too little sex and too much sex. On the one hand, categories relating to low sexual desire risk pathologizing both asexual people and those - very many - who experience fluctuating levels of desire throughout their lives. On the other hand, whilst thankfully not included in the DSM, the popular but deeply problematic category of 'sex addiction' risks pathologizing both those who have a high level of desire and those who enjoy certain kinds of sex such as solo sex, casual sex and cybersex (Richards & Barker, 2013).

### *Diversity*

A model of sexual diversity could much more comfortably contain those with no, low and high levels of sexual desire, as well as attraction to more than one gender, which is currently often erased by binary models (Barker et al., 2012) and diverse sexual practices. It is also in keeping with feminist and queer approaches which have pointed out the phallogocentric and heteronormative assumptions of the current model (Tiefer, 1992; Barker & Langdridge, 2013) Such an understanding of sexual diversity could encompass, for example, solo sex, partnered sex, and group sex; manual, oral, vaginal, and anal sex, as well as other parts of bodies rubbing together for pleasure; sexual fantasy, sex talk, cybersex, erotic fiction, and visual stimulation; and enjoyment of a diversity of roles, bodies, materials, sensations, and dynamics. Under such a model, few - if any - people would be regarded as disordered or dysfunctional given that erections, penetration and orgasm are not necessary, albeit they may well be enjoyed by some people some of the time. And, as authors such as Rubin (1984), Denman (2004), Kleinplatz (2012) and Barker (2013a) have suggested, attention could turn from functionality and normality to the - arguably more important - considerations such as the extent of pleasure or fulfilment experienced, whether or not sex is consensual, a focus on enjoying the process rather than aiming towards a specific goal, expansion of erotic imaginations, and ethical treatment of self and/or other/s involved.

### *Location of issues within society rather than individuals*

The social model shift from locating disabilities within individuals to within society is also a useful shift when it comes to sexual distress. The turn to more social understandings

of bodies and health (Fox, 2012) enables us to locate the body and psychological experience within social norms, societal systems and structures.

For example, vaginal tension and pain on penetration is a common experience for many heterosexual women. It is often treated with the insertion of increasingly large dilators, and/or cognitive-behavioural therapy for sexual anxiety. Applying a more social model approach, , one of us (Meg) worked with a young, white, working class woman - Helen - who was experiencing 'vaginismus'. The work involved considering the psychological meanings that Helen had around femininity and sex, and how these were embedded within wider sociocultural understandings, as well as how they operated through her body during sex. For example, Helen placed great importance on being desirable to others, particularly to her boyfriend, in order to feel valuable. Part of this involved ensuring that her body always looked attractive, so she attempted to adopt certain positions during sex to ensure a flat belly and to avoid potential attention to the parts of her body she regarded as unattractive such as her 'muffin-tops' (a newly created bodily flaw that was currently the focus of many of the images in the magazines that Helen read and an advertising campaign for a local gym).

Like many women, Helen also controlled her bodily functions such that she waited to urinate and defecate when nobody was in earshot, she prevented herself from passing wind, and she was fearful that others would be able to tell when she had her period. All of this contributed to tension, discomfort and pain in her body, particularly in her genital region (Iantaffi, 2013). This was further exacerbated by her anxieties about not being able to provide 'proper' sex to her boyfriend, the fear that she would lose him if she did not, and the underlying belief that it would be terrible to be single (Barker, 2011b; Mize & Iantaffi, 2013). Exploring the social norms in which her distress was located helped Helen to explore different ways of relating to her body, her partner, and to others. Her 'vaginismus' ceased to be an issue when she stopped trying to force herself to have the kind of sex she thought she should be having. Kleinplatz (2012) gives other examples of sexual difficulties being created by medicalised norms about 'proper' sex, and explains how shifting these is a vital part of therapy, alongside helping people to tune in to the meaning of their particular experience.

### *Interdependence*

As touched on previously, utilising a social model could also focus on interdependence around sex, moving away from the current model of dividing dependent disordered people from independent non-disordered people. Current mainstream sex advice books present a very individualistic, neoliberal view of sex, with themes of individuals meeting their needs, making clear autonomous choices, and engaging in self-improvement to acquire sexual capital through techniques and skills (Barker, Gill & Harvey, forthcoming 2015). In contrast, a model of interdependence could re-focus upon sex as relational, and socially situated. For example, it would consider the social power dynamics in play which may enable or constrain agency around practices, communication, and consent (Barker, 2013b). It could also include recognition of the material things that are involved in disordering people, as with the example of stairs and physical disability. For example, long working hours, certain living situations, issues of time and space, money and energy, and gender roles may all restrict the potential of people to perform the kind of great, normal or functional sex advocated by sex manuals and psychiatric nosologies.

### **Sex and disability**

In this second half of the chapter we consider how medicalised understandings of both sex and disability constrain and restrict the sexual experiences and expressions of disabled people. This requires a turn towards social models which are informed by the concept of intersectionality (Crenshaw, 1989) and an awareness of the ways in which sexuality, disability, and other aspects of identity and experience combine.

Much of the literature on disability and sexuality has focused on common assumptions that disabled people are either malignantly sexual or, more likely, asexual (Kim, 2011). We have both come across this in our work within mainstream sex therapy. For example, Meg remembers working with a couple who both had diagnoses of multiple sclerosis and who had been told by multiple health practitioners that sex simply wouldn't be part of their lives anymore and that they should stop thinking about it, despite the vital role it had played in their lives. Alex has met several disabled individuals and couples whose doctors had never mentioned sex and sexuality. They had not been given any resources on how to use props or to consider what they *could* do sexually. Instead they were faced with the silent assumption that sex was not an option for them. Alex also has experienced living with a chronic illness (fibromyalgia) for over 15 years and has not yet met a health professional who has discussed sex with him in the context of his disability.

Medical models of disability are perpetuated and reinforced when disability is mentioned in mainstream sex advice. For example, only around half of the bestselling sex manuals mention disability at all. Whilst the ones that do mention it challenge the myth that disabled people are not sexual, they still distinguish disabled people from everybody else in a binary manner. All of the books that consider disability include it in a separate section on 'disability and illness' or 'sex for special populations' rather than integrating the topic, or considering sex with diverse bodies, throughout the book. This further reinforces the idea that disabled people are 'other', rather than acknowledging the reality that most people will experience some level of illness or disability through their lifespan. None of the mainstream books analysed depict any disabled people amongst the many images of sexual bodies within the manuals (Barker, Gill & Harvey, forthcoming 2015). Disability is presented as an ailment or impairment that individuals have rather than residing in society. They also perpetuate damaging myths such as the idea that the absence of one sense makes other senses grow stronger.

Most sex manuals do not suggest that an active sex life is impossible for disabled people. However, the imperatives of maintaining a varied sex life in order to be a healthy human being, and to maintain a relationship, are reproduced in specific sections for disabled people. The means of achieving this are located in messages like 'committing to making sex a priority' and having a 'willing mind' (e.g. Berman, 2011, p.270-1). It is worth remembering that a disproportionate amount of women experience divorce following the development of a chronic illness or impairment. Given this, the heteronormative advice to be willing to have sex in order to maintain a relationship is concerning as it is likely to create pressures that remove or restrict the possibilities for consensual sex. There is no awareness of such structures and systems of gender, sexuality and disability in these texts, despite their relevance for both the kinds of sex people have and their experience of it. It is telling that the sex advice book *The Ultimate Guide to Sex and Disability* (Kaufman, Silverberg, & Odette, 2007) was written precisely because of the lack of useful advice in mainstream publications.

Even when disabled people are seen as sexual beings, the range of acceptable sexual expression is narrow, and straying outside its purview can easily locate people further from societal norms. For example, queer disabled people are often seen as having

chosen their sexuality because a healthy, heteronormative companion or relationship(s) are regarded as less available to them. Kinky disabled people are also seen in a similar light while also conjuring media-fed images of disabled people as either villains or hapless victims (Iantaffi, 2009). It is rare for disabled people to be viewed not only as sexual but also as sexy, as highlighted by the *American Able* campaign images, which placed bodies with visible disabilities in similar poses to bodies without visible disabilities in a popular US fashion ad campaign (Olsson, 2012).

Disabled people are not expected to have sexual capital or agency and, even when they might be regarded as sexual beings they are rarely, if ever, depicted as such in mainstream images. A recent exception was the popularity of the Oscar-nominated movie *The Sessions*. However, even in this, the aspect highlighted was that of disabled people as consumers of sex work. While this may be part of the experiences of some disabled people, it seems to be the only part that Hollywood sees worthy of representation, perhaps precisely because such depictions do not upset the status quo of disabled people being seen as lacking sexual capital.

The lack of agency for disabled people within the medical model can most clearly be seen in the enforced sterilization of young women with learning disabilities (Brady, 2001; Human Rights Watch, 2011; Stefánsdóttir & Hreinsdóttir, 2013; Tilley et al., 2012; West, 2013). This practice is not uncommon and highlights what happens within a medical model at the intersection of femininity, youth, disability and class. Many of the young disabled women sterilized around the world had no choice about this decision, which was made either by more educated middle class parents with the resources to pursue this, or by professionals in charge of poorer young women with little independent access to a health provider of their choice. In these cases, the denial of disabled people's sexuality becomes marked on the body, designating these young women as incapable of making their own decisions, and as potential victims of heteronormative, unbridled male libido. At the same time, systems continue to contribute to the high rates of sexual abuse among young disabled people, such as residential education, group homes and home settings in which young people are not adequately protected (Nosek, 2001). A social model of disability approach would attempt to tackle these social systems rather than resort to inappropriate, non-consensual medical treatment of individuals.

It is around the issues of sexual agency and consent that the lines between people with physical, sensory and learning disabilities and those with mental health issues begin to blur (if those lines are believed to be present in the first place, of course). What all the above categories have in common is that they are seen as affecting people's ability to consent or have sexual agency in their lives. For example, disabled people who are trans-identified might encounter several obstacles when trying to access transition-related health care services. Their identities are often questioned by professionals, and sometimes family members, who want to ensure their trans\*<sup>1</sup> identities are not a manifestation (or symptom of) of their disability. For example, Alex has seen several young people with autism who identified as trans\* having to fight for their right to access healthcare services with a provider of their choice, because of their parents' lack of belief in their identity as legitimate, rather than 'another obsessive phase'. These issues are even more salient for trans\* people with significant learning difficulties who are under guardianship orders. This situation is even more difficult if they express queer

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<sup>1</sup> The \* after trans denotes multiple possible endings (e.g. -gender, -sexual, -vestite). Trans\* is an umbrella term which aims to capture the broad range of experiences of people who do not remain in the gender that they were assigned at birth.

sexualities. Alex has seen some of these clients disappear from therapy after the initial diagnostic assessment, despite their desire to receive gender-specialist services.

People with mental health issues and users of psychiatric services often experience a similar stripping away of their agency and capacity to consent. For example, Alex often sees clients who have received no information on how prescribed drugs might impact on their sexual desire, nor how medication side-effects (such as interference with menstrual cycle, increased fatigue or drowsiness) might affect their sexual lives. Further, people with mental health issues are too often depicted as undesirable sexual and/or romantic partners in mainstream media, and instead as unstable villains or figures of fun. These depictions are part of the stigma surrounding mental health issues which has a negative impact on the self-esteem and perceived sexual capital of people with mental health issues.

As mentioned earlier, the ability to be viewed as people with agency, capable of consenting to sex, is also dependent on other factors, such as class, race/ethnicity, gender and education. A white, cis<sup>2</sup>, middle class, educated, heterosexual man is likely to be seen as a more viable sexual agent, than someone with disabilities and different identities. It is worth noting that when disabled characters are depicted as sexual (as in *The Sessions*) they generally adhere to all the other identities listed here.

Underlining this disparity are heteronormative foundations that also assume whiteness, class and education (Warner, 1993). Those foundations are seen as central to normative discourses of citizenship, where the ideal unit is the happy, white, heterosexual, middle class nuclear family. To stray from these foundations is itself deviant (Rubin, 1984), and to do so while having a disability is often still regarded as pathological. Within these normative discourses, pervasive assumptions abound. For example, loss of sexual function, usually seen as the ability to have penis-in-vagina penetrative sex, is perceived to be a worse loss for men than women. In contrast, loss of one's reproductive abilities is seen as the ultimate blow for a woman and far greater than any loss of the ability to experience sexual pleasure. Similarly, the importance of creating a sexy appearance is highlighted for women with disabilities, which can include disguising one's disabilities or highlighting other characteristics to compensate, in order to participate in the enactment of acceptable sexual capital. Often men are discouraged from considering a woman with a disability as a potential partner (Shakespeare et al., 1996) especially if those men are not disabled themselves. For disabled men, a woman without disabilities is seen as more desirable as she is perceived to be better able to nurture and care-take according to traditional, heteronormative gender roles.

Disabled people, and especially people of colour and/or with trans\* and queer identities have increasingly challenged these normative discourses in many ways, including contribution to theory development, such as social models of disability and, more recently, crip theory. The latter is based in intersectional understanding and draws on a range of critical theories around gender, race, ethnicity and sexuality to directly challenge normative discourses that limit bodies and pleasure to a simple binary of normative vs. deviant (Sandhal, 2003; McRuer, 2006; 2011). Such intersectional perspectives are also often present in the work of disabled artists. One of the groups that has sought to challenge our understanding of bodies and sexuality through performance is *Sins Invalid* (Berne, 2008), a performing art group of disabled people,

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<sup>2</sup> Cis (short for cisgender or cissexual) is an umbrella term for people who remain in the gender they were assigned at birth.

who place people of colour, queer and trans\* identities at the centre of their explorations of sexuality, embodiment and disability. Through theorizing, educating and performing, disabled people are reclaiming their agency and visibility, while also challenging normative discourses of embodiment and sexuality.

## Conclusions

Drawing together the two strands of this chapter it seems that the expansions of understanding suggested by social models would be valuable for everybody, not only those currently disordered by categories of sexual disorder and those currently disabled by societal understandings.

For example, critical engagement with the narrow binary versions of sex perpetuated in the DSM categories and mainstream sex manuals would enable the kind of expansion of people's erotic imaginations, and move from goal-focused to process-focused sex, which would likely improve everyone's sexual experiences (Kleinplatz, 2012).

Also, it would be a profound - and valuable - shift if people were encouraged to approach each new sexual encounter with the assumption that bodies and minds are diverse, and so they would need to explore this new body/mind and how it works. This would be a radical departure from the current popular belief that a set of sexual techniques can be learnt that will make a person 'good in bed' with everybody (and the implicit caveat that, of course, nobody would want to have sex with anybody who was disabled or sexually disordered/dysfunctional).

The approach taken by the sexual surrogate in *The Sessions* actually makes a pretty good model for all sexual encounters. This is because it involves finding out what turns the other person on through verbal and non-verbal communication, exploring how their particular body works, determining the overlaps between the sexual desires of the people involved and focusing on those areas, and paying attention to the meaning of sex for those concerned (Barker 2013c).. Tellingly, during their analysis of sex manuals, one of us (Meg) was struck that the book they were most likely to recommend to anybody seeking such a text would be *The Ultimate Guide to Sex and Disability* (Kaufman, Silverberg, & Odette, 2007). The advice given in this book is along similar lines and is in stark contrast to most of the mainstream texts they analysed (Barker, Gill & Harvey, forthcoming 2015). Assuming that people are physically, cognitively, and sensorially diverse, and a centrality of sexual ethics, would be better for everybody, not just those who have been disordered or disabled by binary, medical models of sexual function, normality, and disability (Barker, 2013a).

In addition to psychiatric classifications and popular advice-giving, this has major implications for the training of sexual health - and other related - practitioners. It would suggest physical and psychological diversity being addressed throughout such training rather than disability being tacked on in a tokenistic manner, or not addressed at all, as is currently the case (Coleman et al., 2013). It would also suggest that trainees be taught about sexual diversity throughout, rather than having separate training on sexual dysfunctions or paraphilias, (for models that allow for such an approach see Barker, 2011a; Barker, forthcoming 2014).

Returning to the theme of this book as a whole, we hope that this chapter has illustrated that there is much to be gained by applying social models of disability to sexual distress, and by ensuring that social models of disability encompass sex and sexuality as one of many intersecting sets of identities and experiences.

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