

## **Sexual Intimacy, Social Justice, and Severe Disabilities: Should Fair Equality of Opportunity in Health Extend to Surrogate Partner Therapy?**

Kevin Todd Mintz\*

\* Doctoral student in Political Science, Stanford University, [kmintz@stanford.edu](mailto:kmintz@stanford.edu)

### **Abstract**

The 2012 film *The Sessions* tells the story of a man with polio who loses his virginity by undergoing Surrogate Partner Therapy (SPT). In light of ensuing controversy surrounding the legal and moral status of SPT, this article uses Norman Daniels' framework of fair equality of opportunity in health to argue that SPT is a legitimate form of treatment for sexual dysfunctions and should be evaluated alongside other such treatments. I begin by showing how sexual dysfunctions constitute deviations in normal species functioning. I then show that sexual capacities are a matter of fair equality of opportunity because they affect the ability to cultivate the sexual intimacy that is crucial for forming a family and often necessary for maintaining a healthy one. Recognizing that some might object to SPT as a form of prostitution, I proceed by showing how the treatment might avoid some of the objections raised against prostitution, and conclude by affirming that societies committed to fair equality of opportunity in health should work to make SPT legal and safe.

### **I. Introduction**

In "On Seeing a Sex Surrogate", Mark O'Brien, a journalist with polio, describes losing his virginity. O'Brien experienced total paralysis, spending most of his days in an iron lung. This made sex difficult, so he underwent Surrogate Partner Therapy (SPT). During his treatment, O'Brien had sex with a "surrogate partner" with sexological training, who provided him with tools to acquire a positive perception of his sexuality (O'Brien 1990). O'Brien's treatment became the subject of the 2012 film, *The Sessions*.

The film's release triggered political debates. For example, French legislators condemned SPT as prostitution (De La Baume 2013). Disability advocates also disagree on whether SPT appropriately provides access to sexual intimacy for people with disabilities. Some champion SPT as guaranteeing rights to sexual intimacy for them (De La Baume 2013). Others, however, contend that it medicalizes their sexuality, a controversy reflective of the debate concerning the "medical" and "social" models of disability (Shakespeare et al 1996). Whereas the medical model views disability as an individual pathology, the social model emphasizes societal barriers that interact with impairment, creating disability.

SPT is detailed in *Human Sexual Inadequacy*, where William Masters and Virginia Johnson describe how surrogates collaborate with sexologists to treat sexual dysfunction (1970). Today, clients usually meet with a surrogate for 6-10 weekly sessions in conjunction with consultations with a referring psychologist. Client, surrogate, and psychologist collaborate to make sure that treatment is comfortable and effective, as well as to provide continued psychological support after surrogate intervention ends (Volker, personal communication, February 16, 2013). The International Professional Surrogates Association (IPSA) offers training and professional development for surrogates. All IPSA members adhere to a code of ethics protecting surrogate and client. Fees for SPT are comparable to those for conventional therapy (IPSA 2014). Although research on SPT is limited, a recent study of women with vaginismus found that 100 percent of those who underwent SPT succeeded in penile-vaginal intercourse, as opposed to 75 percent of those working with their partners in couple's therapy (Ben-Zion et al 2007).

SPT can be evaluated under various accounts of what justice requires in public health (Dworkin 2000; Nussbaum 1992; Sen 2009). However, here I use Norman Daniels' account of fair equality of opportunity in health to consider whether sexual health is a matter of justice and if SPT is a legitimate treatment for sexual dysfunctions (Daniels 1985; Daniels 2008). I argue that sexual dysfunctions limit opportunities to cultivate the sexual intimacy that is, for many, the foundation of family life.

For Daniels, health needs are conditions constituting a loss of normal species functioning that affect one's access to his/her fair share of the normal opportunity range (Daniels 1985). Included are the elements of human functioning that society recognizes as affecting social opportunity. Fair equality of opportunity is important for this analysis because it holds that individuals should not lose access to the normal range of opportunities (in this case, regarding sexual health) on the basis of arbitrary factors like disability. This allows for an interrogation of how sexual capacities are matters of health, and thus justice.

My argument proceeds as follows. Section II demonstrates how the ability to be comfortable with and express one's sexuality is an essential part of normal species functioning. In Section III, I argue that sexual functioning is a part of the normal opportunity range.<sup>1</sup> Sexual functioning improves an individual's opportunity to experience the intimacy that many view as foundational for establishing and maintaining families. Some might accept this argument while still objecting to SPT, condemning it as prostitution. In Section IV, I dispute this claim. In Section V, I conclude that SPT should be legal and safe in societies committed to fair equality of opportunity in health.

## **II. Sex and Normal Species Functioning**

To establish sexuality as a matter of fair equality of opportunity in health, one must determine how sexual dysfunctions impair normal species functioning. For Daniels, impairments are identified by pathology constituting deviations from a threshold of functioning as measured by widely accepted standards in the biomedical sciences. Accordingly, health is defined as the absence of pathology (Daniels 2008).

Daniels' intent regarding normal species functioning is to develop a baseline for determining what constitutes a health need as opposed to establishing a prescriptive norm.<sup>2</sup> Social norms often determine what constitutes a loss in function, but objectivity is difficult because the diagnosis of dysfunctional pathologies can be rooted in social norms. The pathology underlying dyslexia exists regardless of social context; however, dyslexia only results in functional loss if societies value literacy. Accordingly, not all deviations from social norms are pathological and such deviations should not be categorically treated as functional losses (Daniels 1985).

This point is salient to sexuality, given strong attitudes as to what constitutes "normal." Masturbation was once considered pathological because it was perceived as inhibiting procreation (Daniels 1985). Therefore, one should derive a conception of sexual functioning that avoids incorporating normative judgments about consensual, adult sexual behavior.<sup>3</sup> Hence, it would be false to claim that sex is a component of normal species functioning solely for reproduction. This would restrict "normal" sexual functioning to procreative behavior, excluding from the auspices of sexual health homosexuals, the infertile, and those desiring sex strictly for bodily pleasure.

Here I argue that sex is a component of normal species functioning insofar as it is a primary means through which individuals socialize. Individuals can socialize in various ways; however, given that sexual relations are foundational to sexual intimacy, those who cannot have sex lose the capacity to experience a form of intimacy that most consider crucial to romantic relationships. For most individuals, such relationships, and therefore sexual functioning, enable the formation and maintenance of families, the definition of which is broadly construed here to entail any long-lasting partnership.<sup>4</sup>

This discussion of sexual functioning requires defining sexual dysfunction. Sexual dysfunctions "are impairments or disturbances in sexual desire, arousal or orgasm" (de Silva 1994, 163). According to the Diagnostic and Statistical Manual of Mental Disorders, 5th ed. (DSM-5), sexual dysfunctions can include physical and/or psychological symptoms (APA 2013). I consider deviations in normal sexual functioning to be those resulting from pathologies that inhibit one's ability to engage in desired sexual behavior, rather than behaviors considered "deviant." Sexual deviance becomes sexual dysfunction if a behavior causes distress to an individual (de Silva 1994). However, professional judgments must determine whether to change the behavior itself or to minimize the distress.

It can be difficult to determine what constitutes pathology. This is pertinent for psychological sexual dysfunctions. Consider the case of someone whose shyness inhibits her ability to express interest in or to attract a sexual partner. She may have a psychological pathology that contributes to sexual dysfunction, e.g. a social disorder. However, she might instead just be a shy person. The distinction between those who do and do not have a pathology is not always clear. In such situations, the DSM's clinical guidance and a medical professional's judgement are necessary. Such procedures are subject to misinterpretation or abuse; however, as Daniels and Sabin (1994) note, these serve as a baseline to insure that individuals are appropriately diagnosed and treated.

Accordingly, only sexual dysfunctions resulting from pathologies constitute normal functioning loss.

The relationship between physical and psychological pathologies underlying sexual dysfunction must be examined. Physical dysfunctions might manifest themselves through the inability to progress through the phases of the sexual response cycle: excitement, plateau, orgasmic, and resolution (Masters and Johnson 1966). For instance, the inability to become erect when aroused can indicate an inability to enter the excitement phase. Similarly, individuals with or without severe disabilities can have physical pathologies making the mechanics of sex difficult. Such dysfunctions can result in or interact with psychological pathology. O'Brien's polio made the mechanics of sex challenging, but his treatment focused on addressing a psychological pathology. He recounts, "I wanted to be loved. I wanted to be held, caressed, and valued. But my self-hatred and fear were too intense... I doubted I deserved to be loved" (O'Brien 1990, 1). O'Brien suffered from anxiety that, along with his physical disabilities, constituted sexual dysfunction. Surrogate Cheryl Cohen Greene worked with O'Brien to eliminate his anxiety by helping him understand and embrace his sexuality and to determine how to stimulate a partner given his limitations (O'Brien 1990). Here, both physical and psychological factors needed consideration for O'Brien to experience normal sexual functioning.

O'Brien's experience raises an important question. His treatment culminated in having sexual intercourse. A narrow definition of normal sexual functioning could be the ability to have intercourse, but this definition should be rejected because some with severe physical disabilities may be unable to have penetrative intercourse. Individuals can collaborate with their partners to engage in other sexual behaviors (Sipski and Alexander 1997; Shakespeare 2003). This account of normal sexual functioning allows for this, enabling all individuals to engage in consensual sexual behavior that is satisfying and safe for all participants.

This section demonstrates that sex, in the most expansive sense, is a component of normal species functioning, and therefore a health need. Yet, for fair equality of opportunity in health to extend to sexual dysfunction, one must demonstrate how these pathologies constitute a loss of an individual's fair share of the normal opportunity range. I address this in Section III.

### **III. Sex, Intimacy, and the Normal Opportunity Range**

In determining whether sexual dysfunctions constitute losses in an individual's fair share of the normal opportunity range, one must determine how such pathologies diminish opportunity, and that it is reasonable for people to want to regain the opportunity lost. In this section, I refine my claim about the centrality of sexual functioning to the cultivation and maintenance of families, arguing that sexual capacities lie within the normal opportunity range.

Daniels' framework is rooted in John Rawls' theory of justice as fairness. For Rawls, fair equality of opportunity applies to the institutions comprising society's basic structure, including the family (Rawls 1999). Susan Moller Okin (1989) further notes that the family

has significant effects on one's social position and hence, opportunity. For example, when an individual is part of a supportive family, she will likely have increased support if she becomes ill or acquires a disability. Further, for those with disabilities, increased familial support has been linked to higher levels of educational attainment and employment (Hehir 2005). These examples point to how family support can influence one's social opportunity, which Daniels views as critical in determining whether health needs are matters of justice.

Daniels' normal opportunity range extends Rawls' fair equality of opportunity beyond the realm of jobs and careers to "the array of life plans reasonable persons are likely to develop for themselves" (Daniels 2008, 43). For Daniels (2008), the normal opportunity range is socially defined. In contemporary society, access to the family as a social institution is often considered important. For example, the gay rights movement has advocated for access to marriage and family life as civil rights issues. Governments also recognize that families affect social opportunity as suggested by the over-one-thousand US federal laws regulating marriage and family (Nolo 2014). As such, I contend most individuals' life plans likely include opportunities to form and maintain families.

However, it may not be clear how sexual functioning is related to this opportunity. I claimed in Section II that for most people sexual intimacy is a critical consideration in deciding whether to form and maintain families. To explore this further, consider that the gay rights movement promotes the idea that individuals should be comfortable with the expression of their sexuality. While not all homosexual individuals want to form families, it is reasonable to expect that for those who do, they would want to do so with individuals to whom they are sexually attracted. It would seem counter-intuitive for an openly homosexual man to want to form a family with a woman or an openly homosexual woman to want to form a family with a man. Counter-examples do exist, where two people of different sexual orientations have a non-sexually intimate familial structure; however, such situations are most likely the exception to the rule, establishing the common connection between sexual intimacy and the formation and maintenance of families. I therefore contend that sexual functioning lies within the normal opportunity range as a means of promoting an individual's opportunity to form and maintain a family.

Given that sexual intimacy is, for most, critical to romantic relationships that form and maintain families, people with sexual dysfunctions lose access to their share of this opportunity. One might validly claim that sexual intimacy is not necessary for this opportunity; however, this does not undermine my claim. Individuals experiencing sexual dysfunction likely become disadvantaged because most people value sexual intimacy as a component of family life. Without the ability to experience sexual intimacy, individuals possess a diminished capacity to cultivate long-term romantic relationships. Therefore, under Daniels' framework those experiencing sexual dysfunction should have access to treatment. Their opportunity to form and maintain families should not be diminished solely because of said dysfunction. Simultaneously, because Daniels' framework is concerned with restoration in functioning, individuals are not entitled to enhancement that would extend their share of the normal opportunity range beyond normal species functioning (Daniels 2008).

Similarly, people engaging in sexual relations solely for pleasure should not be excluded from their fair share of the normal opportunity range.<sup>5</sup> Daniels' framework is concerned with protecting health as a matter of opportunity. It is not concerned with the motivations behind individual behavior, but rather the structure of institutions that govern the distribution of health (Daniels 2008). As such, the opportunity to form and maintain a family is a justification for why institutions should consider sexual health a matter of justice, not a justification for denying an individual the right to treatment. This is in accordance with the definition of sexual functioning in Section II, which avoids incorporation of normative judgements regarding consensual adult sexual behaviors. It is also important to recognize that Daniels acknowledges how an individual's life plans may change. The normal opportunity range allows for this (Daniels 2008). Thus, individuals interested in sex solely for bodily pleasure may decide they want to exercise the opportunity to form and maintain a family at a later point in life. Sexual dysfunctions should not preclude an individual from doing so, because the ability to change one's life plan enables individuals to live as free and equal in relation to others (Daniels 2008).

This conclusion becomes clearer with the following parallel case. Cochlear implants have given the Deaf the opportunity to acquire or regain their hearing. However, many in the Deaf community choose not to utilize this technology because they view deafness as part of their identity and not as dysfunction. It would be inappropriate to deny access to cochlear implants because some people choose to remain deaf. It would also be wrong to deny these individuals the opportunity to change their minds.

The same is true of sexual functioning. One might argue that hearing is distinct from sexual functioning because it may have a more direct relationship to Rawls' fair equality of opportunity. Hearing enables access to jobs and careers, whereas sexual functioning does not. While this distinction is accurate, Daniels extends fair equality of opportunity beyond Rawls' conception. While health care institutions would have to determine how sexual functioning should be prioritized compared with hearing, this does not undermine my claim that both functions would affect the normal opportunity range. Therefore, an individual should not be barred from altering his/her plan regarding whether to take advantage of the opportunity to form or maintain a family.

One might claim that an individual's capacity for sexual functioning need not be defended on familial grounds. Sexual functioning improves people's quality of life and some may claim this is sufficient justification for protecting a basic threshold of sexual capacity. This has merit, but lies outside the scope of Daniels' framework, which is concerned with how health affects social opportunity. Sex, therefore, cannot be viewed as an end in itself. Without recognizing that sexual intimacy affects families, one would have to appeal to another form of social opportunity protected by sexual functioning to rely on Daniels' account.

A critic of my argument could claim that he/she agrees that sexual dysfunctions should be considered matters of fair equality of opportunity in health, while rejecting the legitimacy of SPT because of its similarities to prostitution. I address this in Section IV.

#### IV. Distinguishing SPT from Prostitution

*“Seeing a prostitute is like going to a restaurant. Seeing a surrogate is like going to culinary school”* (Cohen Greene with Garano 2012, 233).

Potential critics could point to three ways that SPT might resemble prostitution. Specifically, SPT might perpetuate gender inequalities by reinforcing the notion that women provide sexual services to men because the majority of surrogates are women. Further, clients exploit a surrogate’s bodily autonomy by dictating use of his/her sexual capacities. Finally, the treatment inappropriately commodifies sexual intimacy. Here, I show how the treatment can avoid these concerns.

Exploitation of bodily autonomy underlies much of the philosophical debate regarding prostitution. Some argue that any form of male-female sex work reinforces a male sex right to women’s bodies, forfeiting bodily autonomy for a man’s sexual desires (Jeffreys 2008; Pateman 1983). Others assert women have the right to sell sexual services in markets that protect labor rights other service industry workers enjoy (Fabre 2006).

If SPT exploited bodily autonomy, there would be negative ramifications. Psychologists would be liable for medical malpractice by placing surrogates in unhealthy situations. IPSA’s code of ethics, which all certified surrogates agree to, requires that practitioners shoulder the responsibility of using condoms or other forms of contraception during treatment. It also requires surrogates not be dependent on the emotional and sexual relationships formed in SPT, and IPSA certification can be revoked if standards are not followed (IPSA 2014). Further, a client’s emotional health could be compromised if he/she viewed the treatment as exploitative. This speaks to the importance of collaboration between surrogates, psychologists, and clients. If any of them feel uncomfortable, IPSA ethics standards guide collaborative problem resolution (Volker, personal communication, February 16, 2013).

Critics claim SPT involves the same sexual acts as exploitative forms of prostitution. They further charge that prostitutes could undertake a therapeutic role with clients who are inexperienced or severely disabled. This is a valid point that needs further attention within debates regarding prostitution. However, such claims underestimate the nonsexual components of SPT. For example, Cohen Greene opens her memoir with an account of her relationship with O’Brien and notes that they went through the same body awareness exercises she has done with most of her clients (Cohen Greene with Garano 2012). Also, Cohen Greene notes that in most cases, sex is the culminating step of treatment (Cohen Greene, personal communication, December 9, 2013). Other sex workers might serve in therapeutic capacities, but the overriding purpose of SPT is to help those with sexual dysfunctions confront these challenges. In accordance with Cohen Greene’s quote cited above, clients learn how to create their own sexual relationships.

The more potentially persuasive objection to SPT is, like some types of prostitution, it perpetuates gender inequalities. Consider here Debra Satz’s (1995) argument for an egalitarian objection to prostitution. For Satz, prostitution promotes two kinds of gender inequality. First, women represent a disproportionate percentage of prostitutes, while

men disproportionately utilize their services. Second, prostitution may perpetuate women's lower social status defined by negative stereotyping, unequal power, marginalization, and stigma (Satz 1995). In essence, marginalization occurs because of negative views of sex work. Many of Satz's objections might extend to SPT. The treatment has been primarily utilized by men, and consequently, surrogates might be considered similar to prostitutes working with affluent clientele. Like prostitutes, surrogates may have limited advancement opportunities. Surrogates might experience similar inequalities to those Satz emphasizes.

However, 30 percent of clients seeking SPT are women (Fox 2013). Further, as the study of women with vaginismus suggests, male surrogates provide treatment for women. This data suggests that Satz's worries might not extend to SPT. Additionally, in contrast to Satz's characterization of occupational options for prostitutes, surrogates have opportunities to use their expertise elsewhere. Some have chosen to pursue doctorates, establishing their own counselling practices and becoming scholars of human sexuality (Volker, personal communication, February 16, 2013). Prostitutes could complete training to become surrogates, making this distinction unclear. However, surrogates are highly trained, having a degree of expertise and choice that many prostitutes may not.

Additionally, surrogates' training and SPT's collaboration might render them less susceptible to power imbalances prostitutes sometimes experience. Cohen Greene recalls she has felt unsafe only once in her career, when she discovered a client was sexually abusing a minor (Cohen Greene with Garano 2012). Here, Cohen Greene relied upon surrogacy relaxation techniques to remain calm while she discreetly ended the session. She called the client's psychologist to report the incident and to discuss which of them should contact the police. In this instance, Cohen Greene's professional experience helped to protect her from physical harm. While prostitutes may also develop such coping strategies, surrogates are offered an additional level of support through the psychologist, who is aware of the sessions and is in contact with both client and surrogate. Therefore, SPT may not pose the same safety concerns prostitution can.

Nonetheless, SPT might inappropriately commodify sexual intimacy. On this view, sexual intimacy cannot be sufficiently reciprocated through payment. If SPT did this, the goal of treatment to restore sexual intimacy might be compromised. Cohen Greene's restaurant/culinary school contrast claims that clients pay prostitutes for requested sexual experiences, whereas surrogates teach clients to form sexual relationships. Surrogates sell education with sex as an instructional tool, whereas prostitutes sell sex. Therefore, payment for SPT could be a commodification of education rather than sexual intimacy. Yet, this distinction is not explicit because, although surrogates provide education, the education involves sexual intimacy, and some prostitutes might also provide education.

It is important to recognize that other personal health services might be considered as commodifying other forms of intimacy. A client undergoing psychotherapy pays someone to listen to his/her thoughts and feelings. A personal care attendant might assist an individual with a disability with toileting, dressing, or bathing. These cases

exemplify instances where professionals and clients share a form of intimacy so that service is comfortable, safe, and effective. Like SPT, these cases are scenarios whereby service is not reciprocated in kind. An individual undergoing psychotherapy does not provide counselling and the person being cared for does not dress or bathe her care attendant. Yet, these services are legitimate means of health care because they commodify a service that demands intimacy.<sup>6</sup>

As Martha Nussbaum (2000) argues with respect to prostitution, SPT might only be thought of inappropriately commodifying sexual intimacy because of stigma surrounding sex work. In societies committed to fair equality of opportunity in health, this should be minimized, allowing SPT to be fairly evaluated alongside other treatments. This lays the foundation for Section V.

## **V. Conclusion**

I have argued that treatment of sexual dysfunction is a matter of fair equality of opportunity in health. I began by demonstrating that sexual dysfunctions constitute deviations in normal species functioning. I then argued that sexual functioning would be considered a part of a society's normal opportunity range. I further demonstrated how SPT might avoid some of the contentious issues in debates regarding prostitution. Thus, SPT should be fairly evaluated alongside other therapies when treating sexual dysfunction.

This inquiry presents many directions for future analyses. First, it is unclear if public or private health care institutions should provide coverage for SPT. Second, this analysis could serve as a foundation for conceptualizing what obligations a society has outside the realm of health care in encouraging sexual intimacy. For example, more attention could be given to sex education programs that give students the knowledge and skills necessary to understand and express their own sexuality. Lastly, Section IV suggests that more scrutiny be applied to philosophical and legal arguments that evaluate sex work categorically. This analysis would suggest that SPT should be legalized in countries that demonstrate a commitment to fair equality of opportunity in health. As such, in the US where some jurisdictions recognize a distinction between prostitution and SPT, the treatment should be legalized in all states so that individuals needing treatment are not unduly burdened by travel costs (Cohen Greene, personal communication, December 9, 2013). Legalization would also enable public health institutions to collaborate more easily with IPSA to ensure that treatment is safe.

Although this analysis has focused on providing SPT for people with severe disabilities, my argument should not be interpreted as applying solely to them. Access to SPT is one of many considerations in providing opportunities that make it possible for individuals to acquire the skills necessary to create and maintain healthy sexual relationships.

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### **About the Author**

Kevin Todd Mintz is a doctoral student in Political Science at Stanford University specializing in the study of contemporary egalitarian political thought. His current research involves determining the appropriate role of the state in promoting healthy intimate relationships, as well as applying theories of social justice to special education and other policy areas related to the empowerment of people with disabilities.

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<sup>1</sup> I am not addressing the question of whether health insurance should pay for SPT, only if it should be evaluated alongside other legitimate treatments for sexual dysfunction.

<sup>2</sup> Daniels' framework is the subject of philosophical scrutiny among disability scholars. They criticize his use of normal species functioning because it appears to promote a return to "normalcy" as the primary goal of health care, which they view as being in contradiction with the social model. See Amundson 1992; Silvers 1998; Wasserman 2012. I use normal species functioning as a baseline for determining the scope of sexual health. However, this is an important concern that should motivate future analyses of how best to promote justice in sexual health.

<sup>3</sup> One might suggest that, like dyslexia, sexual pathology only constitutes dysfunction if society values sexuality. This claim is valid. However, it is still important to derive a conception of sexual functioning rooted in a broad justification for why societies value sexuality, ensuring all forms of desired sexual behavior between consenting adults are included within its scope.

<sup>4</sup> Families take many forms and evolve with changing social norms; however, in most cases, sexual intimacy is central to family life. Those with no present interest in forming or maintaining families should still have the opportunity to alter their plans.

<sup>5</sup> This element of my argument builds upon my assertion at the end of endnote 4.

<sup>6</sup> This component of my argument has implications for the division among disability advocates regarding SPT mentioned in the introduction. SPT is a valid treatment; therefore, there is a respect in which it medicalizes sexuality, framing sex as a health need. However, because clients also receive education, SPT might enable individuals to counteract the widely documented stereotype that people with severe

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disabilities are asexual (Shakespeare et al 1996). Hence, SPT shows how the medical and social models of disability can work in tandem to improve the lives of people with severe impairments.