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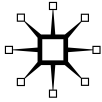
Sexuality, Disability, and the Law: Beyond the Last Frontier?

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SEXUALITY, DISABILITY, AND THE LAW

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

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

Introduction

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

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

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

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

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

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

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

are important (albeit less memorable). When one of the coauthors (MLP) spoke about this topic at an American Psychiatric Association annual meeting, the only comment from the audience was from an APA member who criticized the paper for not directly addressing the special issues raised in the cases of gay patients. At a talk to a major nationally based patient advocacy organization, he was challenged by an audience member who saw “nothing wrong” with staff members having sex with patients, accusing him of being sanist¹ in arguing for a total ban on such activity. When questioned, the audience member answered, “Well, I can see myself wanting to have sex with a patient. Who are you to tell me I can’t?” The coauthor had no response as to his desire but did as to his proposed plan of action (making it clear that any hospital sexuality policy should absolutely forbid such relationships).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I was sitting at my faculty lunch table, and conversation turned to upcoming presentations that we would soon be doing. My colleagues mostly take left-liberal positions on a wide variety of issues, and are generically the exact mix of retro 1960s generationists and early baby boomers that you’d expect. They (appropriately) are quick to criticize any behavior that is racist, sexist, ethnically bigoted, or homophobic. Rush Limbaugh would probably view them as one of his worst “politically correct” horror fantasies. I’m not terribly out of place in this group.

When it got to be my turn, I said that I was going to be speaking about the right of institutionalized mentally disabled persons to sexual interaction. All conversation came to a screeching halt. “Michael, are you serious?” “Are you crazy (sic)?” “Michael, even for you, you’ve gone too far!” “What are you going to say next: that they can get married!?” Et cetera. (Perlin, 2003e, p. 714)

In discussing this, MLP has noted further:

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

When MLP did his initial presentation on this topic⁵ at Kirby Hospital, the talk lasted 45 minutes, and he then asked, innocently, “Are there any

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

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

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

et al., 2008, p. 309). No group faces the same sort of sexual and reproductive restrictions as are faced by persons with disabilities (Ailey et al., 2003).

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

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

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

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

Fourth, it does not appear that changes in patients’ rights law, changes in competency assessments, and creation of sophisticated, valid, and reliable

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

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

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

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

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

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

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

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

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

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