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Selected Aspects of "Alternative" Ways of Meeting the Sexual Needs of People with Disabilities: Sex Worker – Sexual Assistant – Surrogate Sexual Partner

Most researchers focus on sex workers when analysing the phenomenon of prostitution. A definite minority includes studies on service recipients. Few publications refer to the fulfillment of sexual needs of people with disabilities.

In the presented article, the author takes a closer look at selected aspects of the phenomenon involving the fulfillment of intimate/sexual needs of people with disabilities by sex workers, sex assistants, surrogate sex partners, citing selected research results from found materials.

The author outlines the functioning of the phenomenon in relation to legal, ethical, social, and medical issues, using the example of selected solutions applied in several countries to refer to the situation in Poland.

Keywords: disability, sexual needs of the disabled, sex working, prostitution, sex worker, sexual assistant, surrogate sexual partner, sexual assistance, sexual care

Introduction

In most cultures, a normative approach to sex prevails. Kochanowski (2013) points out that, as part of a certain kind of script, sexual behaviour is segregated into: acceptable – considered healthy and acceptable in a given social space – moral, and immoral. The roots from which a given culture originates play an important role. Thus, within the Judeo-Christian heritage, to which Poland belongs, sex is subjected to moral evaluation in relation to its function. The most desirable function is the procreative one, performed within the framework of a permanent,

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monogamous marriage between persons of the opposite sex. Love constitutes another value, with pleasure being forced to give way to the other functions. The compulsory sexual scenario thus established brings with it profits in the form of respect shown to the main actors and recognition as moral citizens, the support of the state offering resources limited or unavailable to citizens honouring values other than the "supreme" procreative value of sex. Sexual behaviour that deviates from this moral centre is exposed to harsh judgement, which intensifies as one moves away from the designated "ideal". Within different cultures, the typical "sexual margin" includes people who decide, for example, to have "casual sex", not realised within a relationship. Kochanowski points out that people who admit to this type of sexual relationship clash with condemnation and denial of the individual's morality, and calls this phenomenon an anti-sexual paranoia. Within this social attitude, immoral sex creates a threat to the individual as well as to society. It is the source of a system of sexual segregation. Representatives of the sexual margin, for their own safety, should take care to conceal the needs they feel and the behaviour they undertake in order to avoid stigmatisation. "Anti-sexual paranoia is not just the beliefs or attitudes of individuals towards those who engage in sex that does not conform to cultural scripts of normative correctness. It is an institutionalised, embedded system of discrimination, humiliation, marginalisation, discrediting, but also the use of various forms of violence (including physical violence) against the sexually insubordinate" (Kochanowski 2013: 19). Prostitution as well as particular "alternative" ways of meeting the needs of people with disabilities are phenomena that often go beyond the framework of the indicated propriety.

Sex workers[2] at the turn of the twentieth century were attributed excessive sensuality (e.g., H. Ellis, W. Morosso), sexual frigidity (e.g., C. Lombroso, M. Hirschfeld, F. Merrick), and sexual indolence (e.g., D. Hammer) in their assessment of sexual desire, with scholars now refuting these beliefs stigmatising prostitutes (Sosnowska 2019: 27). In contrast, people with disabilities[3] are often viewed through the prism of myths about their sexuality – they are attributed asexuality or hypersexuality, and attempts to express their sexuality are often met with resistance from those around them (Hilberink 2022: 820). As Obuchowski notes, the sexual-erotic act under certain conditions acquires social significance: many women only feel self-confidence when they are desired, men with certain defects or low social status gain a sense of importance and value through sexual

[2] I use the terms "prostitution", "sex work", "paid sex", "sexual services" and respectively, "prostitute" and "sex worker" interchangeably, neutrally and without stigmatising individuals, which is raised by some researchers when using the terms "prostitution" and "prostitute".

[3] I use the terms "disabled", "person with a disability" interchangeably, neutrally and without stigmatising individuals, which is raised by some researchers when using the term "disabled".

prowess (Obuchowski 1974: 146). It seems that the perception of sexuality of people engaging in prostitution as well as the disabled is a good example of the attitude towards this social group as such and the rights they should, or should not, have as part of civil society.

The fulfilment of the sexual needs of people with disabilities has been a taboo subject, and many stereotypes have grown around this issue (Lew-Starowicz 1999). As Trojanowska notes, "the perception of people with disabilities as incapable of leading an active and satisfying sexual life has no cultural or ethnic boundaries" (2020: 62). Slowly, the situation of the perception of sexuality of disabled people is changing, both within social and scientific discourse and on the ground of law. The Convention on the Rights of Persons with Disabilities, adopted by the United Nations General Assembly on 13 December 2006, was ratified by Poland on 6 September 2012. It contains, among others, provisions prohibiting discrimination against persons with disabilities as well as mandating the creation of conditions that enable the exercise of rights on an equal basis with others, and constructing solutions dedicated to persons with disabilities.

People with disabilities are less likely than non-disabled people to report leading a satisfying intimate life. Accommodation limitations, lack of privacy, and insufficient sex education are some of the most common barriers they face (Hilberink 2022: 820). The awareness and knowledge of the sexuality of people with disabilities and the declarative acceptance of the fulfilment of the sexual needs of society intersect with the difficulties that disabled people still face both when trying to use "standard" (culturally perpetuated) and "alternative" ways to fulfil their desires (Ślęzak 2016a: 60). "Alternative" ways of sexual fulfilment include sexual services provided by prostitutes, sexual assistants and surrogate sexual partners[4].

Given the different models of normative regulation of prostitution around the world, it is worth noting their impact on the realisation of "alternative" ways to meet the sexual needs of people with disabilities. The two phenomena are correlated to the extent that prostitution itself is not a rigidly defined phenomenon that is locked into a fixed framework with regard to its manifestations, types, and boundaries of what falls within and what goes beyond the provision of sexual services. Also, an in-depth analysis of the phenomenon allows conclusions to be drawn as to the diversity of models of normative regulation of prostitution and the social acceptance of the phenomenon often independent of legislated law (Sosnowska 2019). Similarly, with "alternative" ways of satisfying the disabled, we have to deal with the lack of a rigid nomenclature, the interchangeable use

[4] On the area of sexual rehabilitation, deliberately omitted in this article, write, among others, Auoil (2010), Adamczyk et al. (2012), Ślęzak (2016b).

of terms for the same or different phenomena, as well as a phenomenon that arouses controversy in itself.

It is noteworthy that both phenomena, the provision of sexual services – including "alternative" ways of fulfilling the sexual needs of people with disabilities – and the sexuality of people with disabilities, belong to a taboo zone. Due to the limited research in this field, it is difficult to come to general conclusions about "alternative" forms of satisfying the desires of people with disabilities. The analysis of foundational data can only provide a general perspective on the issue by relating it to a variety of research findings from several countries. The aim of this article is to highlight the problems arising from the fluidity of the terms and of the scope of "alternative" sexual services provided to people with disabilities, to outline how they are implemented and the legal challenges faced by service providers as well as service recipients, to cite examples of research findings from the still scarce literature in this area, to signal the convergence of both phenomena and challenges, including the issue of stigma faced by service providers or people with intellectual disabilities, where the realisation of the right to the fulfilment of sexual desires is not as obvious as it might seem.

In view of the above, it is worth analysing selected aspects, starting with an overview of disability models and the topic of the sexual needs of people with disabilities, then moving on to introduce sex workers, sexual assistants and surrogate sexual partners as representatives of service providers in the field of "alternative" ways of fulfilling the intimate needs of persons with disabilities, and presenting an overview of the problems encountered in the realisation of their services, identified on the basis of the cited research results, introducing in turn the legal and ethical aspects and some arguments used in the debate "for" and "against" the described sexual services for persons with disabilities, ending with an outline of the situation of the phenomenon in Poland.

Models of disability

There are currently mainly two models of disability. In the medical model, where the focus is placed on the effects of illness or injury, people with disabilities are offered medical services to combat deficits and impairments perceived as a problem, a disorder, a taboo phenomenon (Ciechomska et al. 2021: 123). In the social model, disability is considered as a social construct and barriers are imposed on functionally diverse people in a given context, so it is important to eliminate architectural impediments and attitudes that hinder the equal opportunities that every citizen should be provided with (Gutiérrez-Bermejo et al. 2022: 348). The social model is linked to the biopsychosocial model, which is currently gaining importance, in which disability is seen as a process in dimensions that go beyond

the biological or social spheres and include psychological, cultural, social, and political perspectives, among others (Ciechomska et al. 2021: 123).

There is noticeably less acceptance of people with intellectual disabilities than physical disabilities (Giryński et al. 1993; Kijak 2007). Kijak points out that while entering into a collegial and friendly relationship with a person with a disability is considered by the majority of non-disabled respondents (N=130), emotional relationships are considered by only 4% of men and 3% of women (Kijak, 2007: 19). The researcher also believes that although she observes a shift from biologism to a sexual rehabilitation approach for people with intellectual disabilities, despite seeing evidence of the granting of "specific sexual rights and freedoms to people with disabilities (…), there is still an infantilisation of adulthood for people with disabilities" (Kijak 2011: 150). At the root of the denial of the right to express sexuality and establishing sexual relations for people with intellectual disabilities, Kijak notes the perception that they are either "perpetual children" with no educational needs, or dangerous persons due to the recognition that they are unable to control their own urges. She judges the denial of the existence of the sexuality of people with intellectual disabilities as immoral and equates this action to taking away part of a person's personality (Kijak 2011).

Many researchers and specialists speak in favour of sexual education and the right to make one's own decisions by persons with disabilities, pointing to the right to freedom and equality (e.g., Izdebski, Długołęcka, Fornalik, Kijak, Lew-Starowicz). On the other hand, the conviction of the inheritance of disability raised by other researchers provides a basis for non-acceptance of the realisation of sexual life and procreation by people with intellectual disabilities (Pilecka 2004; Ślęzak 2016a: 61)[5].

Izdebski's (2005) research shows that in a survey group of 1004 people over 15 years of age, acceptance of sexual fulfilment for people with physical disabilities is expressed by 69% of people (full acceptance 74%) and for people with intellectual disabilities by 54% (full acceptance 39% of respondents), (Ślęzak 2016b: 60). McConkey and Leavy's (2013) 2011 survey of 1,000 Irish respondents indicated that 69% of respondents acknowledged the equal right to sexual fulfilment for people with physical disabilities (50% in 2001), and only 45% for people with intellectual disabilities (Gilard et al. 2019: 111).

Kijak notes that "methods of psychosexual support for people with intellectual disabilities have been developed in many countries. Numerous counselling and sex therapy programmes, used in Western European countries and some states of the United States of America, often abound with modern solutions and ideas. In Poland, there are still few such examples" (Kijak 2011: 149).

[5] More on the approach to the sexual sphere in people with profound intellectual disabilities, including the division into desexual-avoidant orientation, sexual-totally-acceptant orientation, and sexual-subliminal orientation is written by Nowak-Lipinska (1996).

Sex worker

There is no single definition of sex work, and it is noteworthy that an accurate understanding of the phenomenon plays a significant role in the creation and establishment of normative acts and the consideration of new forms as well as the implementation of public policies in this area. Błońska (2010) draws attention to the relationship between the way prostitution is defined and the scientific discipline. Syrek (1979) points to three levels of consideration of the definition of the phenomenon: historical relativism, geographical relativism, and the structural plane (Ślęzak 2016a: 53). As a researcher, "I consider prostitution to be the provision of sexual services, in exchange for material or non-material benefits received, without any link to a specific form of remuneration, with a lack of emotional connection between service provider and recipient, and with associated issue of the number of clients or the type of services provided" (Sosnowska 2021: 110). In the case of sex workers, we may be dealing with people who choose to receive additional training to assist people with disabilities, or their services are performed as "standard" and as for any other client. Ślęzak notes that prostituting female respondents in Poland express aversion to services provided to people with disabilities, by pointing out the greater commitment required with a client less able than others (Ślęzak 2016b). In addition, people with disabilities are warned against using prostitution services because of, among other things, the risk of theft (Kaufman et al. 2013). WHO/UNFPA (2009: 6) point out that people with disabilities are three times more likely than non-disabled people to be victims of psychological violence, physical violence and rape, and that intellectual disability predisposes to an even higher rate of risk, and while these are general findings and do not refer directly to relationships with sex workers, they highlight an issue that is also relevant in relation to paid sexual services offered by sex workers.

Liddiard's research into the motivations of 16 male respondents with disabilities using the services offered by female sex workers found that, unlike non-disabled men, they were not primarily rooted in a male "need" for sexual gratification. Among the responses were: learning about one's own body and exploring one's own sexual possibilities; improving skills in relation to future sexual relationships with non-commercial sex partners; being able to have sexual experiences to talk about with friends – inclusion in male sexual culture; issues related to access restrictions to potential sexual partners; avoiding discrimination; financial constraints – costs associated with dating venues; and the sense of autonomy, agency, control and independence obtained by purchasing the sex work services (Liddiard 2014: 845–849).

Other "alternative" ways of fulfilling the sexual desires of people with disabilities

In addition to the use of paid sexual services provided by prostitutes, there are other forms of assistance to persons with disabilities. Two terms chosen by researchers appear in the literature: "sexual assistant" (Morales et al. 2020; Kessler 2008; Krauze et al. 2010) and "sexual surrogate partner", (Noonan 2007; Rosenbaum 2014), describing different forms of assistance; interchangeably used for the same forms, as well as a combination of the two terms when translating, e.g., "sexual surrogate" (Długołęcka et al. 2013).

Rakić, in my opinion, most accurately points out that, unlike the sex assistant, the sexual surrogate partner is not limited to clients with disabilities, but provides services to those with sexual dysfunctions regarding ejaculation, vaginismus, or with lack of sexual experience (Rakić 2020: 2121).

It is worth recalling other terms that appear in the literature to refer to similar phenomena that differ in nuance from one another: "sexuality advisors", "sexual supervisors", "surrogate partnership", "sex surrogate", "facilitated sex", "intimate accompaniment", "erotic accompaniment", "sexual accompaniment", "sensual partner", and "intimate and erotic assistant" (Gutiérrez-Bermejo 2022: 351). In Denmark, sex workers completing the course receive a sexual adviser certificate; in the Netherlands, sex care is a whole distinct field.

For the purposes of this article, I assume that a sex worker offers his or her services without any prior training geared to the specifics of the disability. A sexual assistant is a person trained to meet the sexual needs of a person with a disability, and differs from a sexual surrogate partner in that there is no additional interaction with the client's therapist, as discussed in detail further below.

Sexual assistant

"Sexual assistance is a sexual accompaniment service for people with disabilities that provides educational services about sexual practices and support services for sexual activity to meet the sensual or sexual needs of clients, bearing in mind the specific characteristics associated with their disability" (Morales et al. 2020: 20). The emergence of the sexual assistant profession stems from the social movements of the 1970s, emphasising the citizen's right to equality. The awakening awareness of the same sexual needs of people with disabilities as those without physical and intellectual disabilities contributed to the emergence, mainly in Europe, of

initiatives to promote sexual assistance. In terms of legislation, the legal status of sexual assistance is often identical to legislation covering prostitution.

As Kessler (2008) points out, sexual assistants, unlike sex workers, are distinguished by their training, ongoing supervision, frequency and duration of services, social acceptance of their work, humanistic approach and discretion (Morales et al. 2020: 11). Training and supervision allow for a better "mental balance" than in the case of prostitutes. With regard to people with mobility disabilities, physical assistance may also be necessary, such as undressing, transferring from a wheelchair, e.g., to a bed, helping to position the body appropriately (Długołęcka et al. 2013: 162).

A sexual assistant undergoes a rigorous selection process. Kessler (2008) presents the recruitment process for the first training of sexual assistants operating in French-speaking Switzerland in 2008. Criteria included age of the candidates, who had to be at least 30 years old, relevant qualification documents, including a handwritten letter of application, a curriculum vitae, a certificate of current employment (the candidate was usually paid a minimum of 50% of the total fee for the service), a certificate of morality, a criminal background check, and a registration fee. The second stage was an interview with a practising sexual assistant, and the third stage of the process was reserved for selected individuals. Due to the predominance of men over women among the candidates, it was necessary to limit them, as gender parity was assumed at the outset. According to Kessler, the disproportionality was determined by two factors, the cost of the training, hindering women due to their lower financial autonomy, and the men's freedom of action and power to self-determine outside their homes (Kessler 2008: 54–57).

The training programmes vary in detail from country to country, but are similar to the one conducted in Switzerland, during which, for 300 hours, sexual assistants learn about topics such as: detailed knowledge of different disabilities, legal knowledge, sexuality and sexology in the field of disability, knowledge of corporeality, including body language and eroticism, ethics, institutional contexts, and the role of companions. Additionally, at the end of the programme, supervision is maintained by an experienced worker or a support group to ensure that the sexual assistant is mentally balanced and has emotional support as well as space for reflection and discussion (Morales et al. 2020: 21).

Research on workers' preferences shows that the remuneration of services is secondary to them, the intentions that motivate sexual assistants are the desire to help, altruism, a willingness to provide disabled clients with sexual autonomy and to increase their quality of life as well as their social integration. Services provided to disabled people limited to three or four times a month, not oriented towards maximisation of financial gain, require having a main source of income through other work (Rosenbaum 2014: 325).

Gilard, Muñoz Sastre and Mullet surveyed 238 French respondents about the sexual assistant services provided to physically disabled persons. For this purpose, they used a set of 30 vignettes with different scenarios, concerning the situation of a minor when, being quadriplegic, he expressed his sexual needs to a nurse who arranged an appointment at the hospital with a sexual assistant. The scenarios were developed taking into account the following relationships: gender of the patient x; identity of the assistant (same-sex nurse, opposite-sex nurse, opposite-sex nurse who was trained to be a sexual assistant, prostitute, ex-boyfriend/girlfriend); x attitude of the parent (agreement with the procedure, agreement with the procedure and the assistant's remuneration, disagreement with the procedure). The overall results indicated that 21% of the respondents expressed their disagreement with this type of assistance, 13% were in agreement depending on the identity of the assistant, while 14% of respondents were in agreement providing that payment for the assistance was absent, 8% indicated the need for parental consent, 28% indicated unconditional acceptance, and no specific response was obtained for 17% of respondents. Taking into account religiosity and education, the researchers indicated that male atheists most often always accepted the phenomenon under study, while regular religious practitioners and those with lower education mainly expressed disapproval. Those with higher education and who were also regular observers of religious practice were characterised by an attitude of non-acceptance (Gilard et al. 2019: 109).

The literature is quite scarce on the educational needs of sex care workers offering serviced to people with disabilities. There is also little research on the motivations of people applying to work as sexual assistants. Findings from a study in Italy indicated motivations such as providing assistance to disabled people, enabling disabled people to have sexual experiences, an earning motive, flexible working hours, and support for people with disabilities (Hilberink et al. 2022: 821). A 2021 study among 29 sex care workers found that an important motive of the respondents was that there was not enough attention paid to sexual support for disabled people and that they wanted to make a personal contribution to their sexuality. They indicated a fairly good level of knowledge, with a desire to improve skills in working with clients with mental health problems or autism spectrum disorders, or who had secondary problems caused by physical disabilities. Other aspects included learning to avoid the effort involved in certain positions, and learning boundaries in terms of own sexual pleasure (Hilberink et al. 2022: 831).

Sexual surrogate partner

Sexual surrogate partners are "women and men with professional training who function in place of a non-existent sexual partner during sex therapy using a short-term, limited psychosocial/behavioural therapy model" (Noonan 2007: 1441). According to the recommendations of IPSA (International Professional Surrogates Association), the training of Israeli surrogate partners lasts 40 hours and follows a thorough screening of candidates (Rosenbaum 2014: 323) Typically, the surrogate partner will work with the client, who simultaneously meets with the therapist who directs the client's therapy. Thus, there is a therapeutic triad: client – therapist – surrogate partner. The therapist consults together with the sexual surrogate partner before and after contact with the client. A surrogate partner who does not work with the therapist is considered by IPSA to be outside the professional standards accepted in this type of support.

For legal, ethical or therapeutic reasons, a therapist will not conduct therapy with a person who is in an ongoing sexual relationship or is married. Clients of therapists and sexual surrogate partners are people who are characterised by the presence of sexual disorders, physical or psychosocial limitations. Clients are mainly heterosexual men with sexual and emotional inhibitions or dysfunctions that have prevented or delayed entry into intimate relationships, e.g., childhood abuse, premature ejaculation, erectile dysfunctions, or – for middle-aged men – previous lack of sexual intercourse. Female clients include those with a history of childhood abuse, negative body image, anorgasmia, vaginismus, or sexual shyness.

Noonan's (1984) findings in a group of 54 people indicated that 87% of the professional time of sexual surrogate partners was spent on non-sexual activities such as counselling, sex education (34%), learning social skills (5%), emotional support, sensuality education, relaxation, or self-awareness (Noonan 2007: 1441–1442). Noonan indicates that clients are people with sexual disorders, but does not link them to disability, nor does she link the work of sex care workers to disability support. Compared to sex workers who carry out clients' desires, sexual surrogate partners act according to the requirements of therapeutic goals in cooperation with the therapist (Rosenbaum 2014: 325).

According to Fleckelton (2013), when a surrogate partner's behaviour goes beyond the transmission of information and enters into an interaction involving intimate touch, it becomes a provision of paid sexual services, unless it is an altruistic, non-financial sexual act with a person with a disability, so when there is payment for sexual service we are dealing with prostitution. Due to ethical, legal and clinical issues in considering referral of a client for therapy by a professional, the distinction between the provision of sexual services and sexual surrogate therapy

is very important. Prostitution is related to financial gratification for engaging in a sexual act, the aim being the sexual gratification of the client. Sexual surrogate therapy does not necessarily focus on sexual gratification, stimulation or intimate touch, instead the partner focuses on helping clients build social and physical self-awareness, as well as awareness and skills related to physical and emotional intimacy, therefore it is about learning healthy intimacy. As Fleckelton points out, the aspirations of sexual surrogate therapy services are lofty, focusing attention on holistic goals, not just on penetration or other sexual interactions. Looking at the financial side, gratification takes place every time, as with prostitution. When giving an assessment of the legal situation, it equates sex replacement therapy with prostitution. Local Australian law regulates the existence and supervision of brothels, establishes licensing, hygiene controls, underpinned by, among other things, the idea of protecting the physical health of clients. Thus, in order not to break the law, a sexual surrogate partner should participate in the licensing system in order not to expose themselves to criminal liability associated with illegal prostitution (Fleckelton 2013: 651–652).

The researchers point out that there is little data for evaluation of the effectiveness of therapy with surrogate partners, especially presenting results without a control group. Masters and Johnson (1970) believed that therapy was effective in 63% of men with primary erectile dysfunction and in 78% with secondary dysfunction. The results of Cole's (1982) study indicated that in a retrospective evaluation after 6 months (N=150), which also included 17 women, 73% of the subjects maintained improvement. Subsequent findings (Dauw 1988) indicated that 89% of therapy clients (N=501) had resolved their sexual problems, 5% had partially satisfied their needs, with it being noteworthy that only 6% of respondents had completed therapy. Apfelbaum's (1984) study involving 407 participants indicated that 60% were fully successful, 21% were partially successful, 7% saw no change and 1% experienced a worsening of their situation as a result of therapy. In 2007 (Ben-Zion et al. 2007), a study done in Tel Aviv was published based on data from 16 female clients with vaginismus receiving therapy with male surrogate partners and a control group in which the therapy was conducted with subjects' own partners. All women working with a surrogate partner achieved pain-free intercourse compared to 74% of respondents in the control group. 19% of treatments were interrupted by couple separation. Both groups reported similar levels of satisfaction with the process and outcome of therapy, with women using sexual surrogate partners completing treatment 2 months before women in the control group, which may be explained by a lack of need to engage in relationship dynamics and sexual partner problems (after Rosenbaum 2014: 324).

Legal aspects of sexual services provided to persons with disabilities

While analysing Australian and New Zealand models of prostitution regulation, Crofts and Summersfield (2007: 308) present the following conclusion:

> In order to be effective, the system should reflect a clear licensing model, guided by principles of fairness, transparency, rationality and efficiency. A strict and intrusive registration system is not beneficial to those in the industry or the community. Difficulties in obtaining a licence due to onerous requirements or discretionary granting can lead to the continuation of illegal work and perpetuate poor working conditions for such workers. Licensing models that combine social control and regulation do not necessarily lead to effective regulation of the industry, as indicated by the extent to which certain parts of the industry remain unregulated. This creates the danger of a two-tier system in which much of the industry continues to operate under a criminalisation model (after Sosnowska 2019: 135).

Due to the sexual nature of the work, the position of many countries towards the legalisation of sexual assistance is analogous to that taken towards the phenomenon of prostitution. Where the provision of paid sexual services is permitted and regulated, there is acceptance of sexual assistants, and the prohibition of prostitution is linked to the prohibition of the legal existence of sexual assistance (Morales et al. 2020: 20). However, this is not a rule. An example of this is Sweden, where sex workers are not punished, only clients, but there is no acceptance of sex assistants (Mannino et al. 2017: 500). In the United States of America, on the other hand, where most states treat paid sex work as a crime, sexual surrogate therapy delivered with a therapist has existed since the 1970s. In Germany, where the self-employment of prostitutes has been regulated since 1998, the legal status of a sexual assistant was regulated in 2017 (The Prostitute Protection Act), and in Switzerland in 2008.

In some countries there are services that facilitate sexual engagement for disabled people, e.g., in Sweden, the Netherlands, Denmark, Italy, the UK, Australia, Canada, Japan (Hilberink et al. 2022: 820). Examples of organisations and communities of sex workers or collaboratives for disabled people are the TLC Trust in the UK, Touching Base in Australia, BodyUnity in Switzerland (Geymonat 2019: 2014–2015), Fabs (Welfarr Group Disabled and Sexuality) (Długołęcka et al. 2013: 162), Lovegives in Italy, and APPAS (Association for the Promotion of Sexual Accompaniment) in France (Gutiérrez-Bermejo et al. 2022: 350).

Hilberink, van der Stege, Kelders (2022) point to the existence of five Dutch service providers that facilitate sex work and sex care. Some of the providers identify themselves as specialising in prostitution for people with disabilities, others see sex care in analogy with the rest of the needs associated with clients' disabilities and are

opposed to employing prostitutes in the role of helping people with disabilities, as this is a form of professional care. As the authors note, in the Netherlands there is not yet training for disability support workers in the sense of sex care workers, and consideration is being given to using Partner Surrogate Therapy by Masters and Johnson (1970) to provide a framework for training and educational goals and to designate sex care as a legitimate care profession (Hilberink et al. 2022: 820–821).

Ethical aspects and some arguments "for" and "against" sexual assistance

Everyone's successful sex life consists of three factors: sex drive, sexual acts and individual sexuality. For people with disabilities, primary and secondary dysfunctions may occur at each of these levels (Kirenko 2006: 67). Physicians, psychiatrists, psychologists, social workers, therapists of persons with disabilities realise that the sexual needs of their patients/clients are important, and ignoring them is not in line with the concern for the right to sexual expression for all people, stemming for example from the Convention on the Rights of Persons with Disabilities. When confronted with a request for a referral to professionals who can help with an intimate part of a person's life, they may face dilemmas that also arise from the range of legal considerations in a particular country.

The discourse related to sexual assistance for persons with disabilities is in some ways reminiscent of the debate about prostitution in Europe in the past (Wagenaar and Jahnsen 2017) and there is a polarisation of the environment into "for" and "against" sexual assistance for persons with disabilities. Among the "pro-assistance" arguments, there is a vision of skilled, responsible and publicly controlled workers who provide essential services to disabled people with limited opportunities to realise their rights. Opponents view sexual assistance as a manifestation of exploitation, commodification of women and promotion of prostitution. This view ignores the issue of possible male sexual assistance provided to women with disabilities (Geymonat 2019: 215).

The controversy over the role of sexual assistants concerns the boundary between prostitution and the provision of support/care services to people with disabilities (Limoncin et al. 2014, Hilberink et al. 2022, Freckelton 2013). The funding of sexual assistants is also an issue. For example, organisations supporting sexual assistants and clients lobby for state participation in refinancing services and treating them as "prescription sex" (e.g., in Germany). A problematic issue is the provision of sexual services to disabled people that may put clients at risk, without the existence of qualified workers in the support system. The discourse broadened to include

the basic sexual needs of people with disabilities touches on legal issues – sexual assistance seen as a way of ensuring one of the rights of people with disabilities.

Situation in Poland

In 1997, amendments to the Polish Penal Code were established. A prison sentence of between 1 and 10 years was replaced by three years of imprisonment for procurement (inducing someone to engage in prostitution), pandering (profiting from someone's prostitution) and facilitating prostitution (for financial gain). Procurement was linked to soliciting prostitution for the purpose of obtaining financial gain. The term "practising prostitution" replaced the previously existing "practising fornication" (Sosnowska 2013: 191). The 2022 amendment to the Penal Code did not change the legal situation of prostitution, which is not punishable, nor is it regulated by law so as to ensure the protection of sex workers in terms of their professional situation or to indicate the rules for the provision of services with regard to the role of service provider and service recipient. The same applies to the role of sexual assistants and unsanctioned sexual surrogate therapy.

Poles have rarely been asked about attitudes to the legalisation of prostitution, so it is not possible to address current social expectations. A survey by OBOP (1994) reveals that 72% of respondents condemn prostitution, 80% of whom were women. 63% of men expressed a negative attitude towards the provision of sexual services, and a lack of condemnation was presented by 32% of men and 16% of women (N=1031). 35% of respondents were in favour of the legalisation of brothels and one in six against, seven out of ten women and 48% of men were against it. In a subsequent OBOP survey (1994), 79% of respondents condemned prostitution, while 16% were for it, and the provision of sexual services ranked sixth out of 18 condemned behaviours mentioned by the researchers (N=980). In a more recent CBOS survey (2021), when analysing Poles' attitudes to such phenomena as having sex before marriage, homosexuality, and the use of contraceptives, among others (as in previous surveys from 2005, 2010, 2013) prostitution was not included among the morally controversial behaviours assessed. Similarly to the CBOS survey (2009) on the assessment of socially reprehensible behaviour, the provision of sexual services was not included.

In terms of the law protecting persons with intellectual disabilities, Article 198 of the Penal Code reads as follows: "Whoever, taking advantage of the helplessness of another person or the lack of ability of that person to recognise the meaning of the act or to direct his or her conduct, leads that person to have sexual intercourse or to submit to another sexual act or to perform such an act, shall be subject to the penalty of imprisonment for a term of between 6 months and 8 years" (Rada

Ministrów [Council of Ministers] 2022). In practice, an intellectually disabled adult consenting to sexual intercourse may be considered a victim of the offence when it is shown that he or she is not aware of a particular act, and the authorities can prosecute the perpetrator without need for the victim to press charges. Thus, in a situation where these persons use the services of a prostitute as well as a sexual assistant, it is likely that under Polish law sexual contact or any intimate activity could be considered as violence. With regard to parents and other persons caring for an intellectually disabled person, we are faced with further considerations, namely whether they could be held responsible for failing to provide assistance in the case of sexual abuse of the mentee or, going further, for participating in quasi-prostitution phenomena (Długołęcka et al. 2013: 185).

According to Polish law, there is therefore no possibility of any organised form of assistance to facilitate access to sexual surrogate partners as exists in select countries. According to the results of the National Population and Housing Census, there were 4.7 million persons with disabilities in Poland, representing 12.2% of the population. Izdebski's 2002 study (N=400) shows that one in five clients paying prostitutes for sex is a disabled person (2012: 585). When evaluating the possibility of paid sex services with state reimbursement for disabled people, if considered as a form of reimbursement as exists in the Netherlands, 63% of British wheelchair users were enthusiastic about such an arrangement (Focus.co.uk 2011). In the same period, Polish disabled people would reject such an offer if it were available to them – 86% of women and 67% of men questioned (Gazeta Lubuska.pl 2012), (after Sosnowska 2012).

Krause, analysing the phenomenon of the normalisation of sexuality and contact with the opposite sex of people with intellectual disabilities, including the obstacles arising from living in Polish residential institutions as well as in family homes, points to such prejudices about the sexuality of people with disabilities as the lack of adequate contraception, the attempt to reduce the risks associated with possible motherhood and entering into permanent relationships, emphasising that there are support solutions already used in other countries. She draws attention to the state support of sexual assistants in the Netherlands in opposition to the avoidance of addressing the issue of disability sexuality in Poland (Krauze et al. 2010: 37–38). In the absence of a broad debate, in-depth research and actions aiming at a comprehensive approach to the sexuality of people with disabilities, including an extensive system of counselling or therapy oriented to the individual needs of the client, it is difficult to state that there is space for discourse and possible sanctioning of the reimbursement of sexual surrogate services presented in the article.

Summary

The sexual needs of people with disabilities who do not realise them within a socially acceptable marriage or permanent relationship are a taboo subject. The use of services offered by prostitutes is quite common due to the lack of available alternatives, but not fully adapted to the needs of people with disabilities (Ślęzak 2016b). Sex care provided by sexual assistants/sexual surrogate partners, on the other hand, is not only difficult to implement, but requires special systemic preparation of the person providing such services as well as the clients, including consideration of financial issues, where the wealth barrier may somehow marginalise the sexual needs of people with disabilities. The role of the sexual assistant or the sexual surrogate partner involves challenges such as defining terms, the issue of stigma that affects sex workers, educational as well as legal challenges, assessing the effectiveness of surrogacy, aspects of funding, ensuring the safety of people with disabilities. This is only some of the issues that were raised. However, Wagenaar and Jahnsen (2017) rightly pointed out a similar polarisation in the discourse that has concerned the phenomenon of prostitution, so it can be assumed that this is only the beginning of a search for a consensus or of development of this phenomenon in general, also in relation to the sexual needs of Polish people with disabilities.

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