Sexuality and Disability
https://doi.org/10.1007/s11195-022-09760-0

ORIGINAL PAPER

Educational needs, motives and experiences of sex care workers for people with disabilities in the Netherlands

S. R. Hilberink[1] · H. A. van der Stege[1] · Y. Kelders[2]

Accepted: 21 August 2022
© The Author(s) 2022

Abstract
In some countries, personal assistants may facilitate sexual engagement of people with disabilities. A specific form of facilitating sexuality are services that offer paid sex with sex care workers. In the Netherlands, there is no training available for sex care workers. To provide input for such training, this study examined sex care workers' (perceived importance of) knowledge about sexuality and relevant aspects of sex care, their educational needs, motives for becoming a sex care worker, and experiences. An online survey was completed by 29 sex care workers (response rate 52%). The sex care workers expressed high importance of knowledge and generally reported good, but slightly lower current knowledge levels on these aspects. Educational needs included both general and disability-related sexuality and sexual problems and how to deal with problem behaviors and/or emotional disinhibition. Some participants indicated that learning how to prevent physical strain was important. The importance of setting boundaries was reported. Overall, participants experienced little stigma, although few reported negative experiences. Important motives for sex care work included the lack of attention to sexuality support for clients with disabilities and wanting to contribute to clients' sexual citizenship. The formulated educational needs may be helpful in the development of such training. In addition to knowledge and practical skills, the training should pay attention to discovering and setting boundaries, providing a safe space for reflection on one's own body experience and ethics, as well as considering the clients' perspectives.

Keywords Sex Care · Sexual Facilitation · The Netherlands

✉ S. R. Hilberink
s.r.hilberink@hr.nl

[1] Rotterdam University of Applied Sciences, Research Center Innovations in Care, P.O. Box 25035, 3001 HA Rotterdam, the Netherlands

[2] Rutgers, Dutch Center of Expertise on Sexual and Reproductive Health and Rights, P.O. Box 9022, 3511 MJ Utrecht, the Netherlands

Published online: 26 October 2022

Introduction

Sexuality is an important aspect of human life and contributes to identity and physical and psychological health [1–3]. For people with disabilities (PWD) (physical, intellectual, developmental), sexuality is equally important. However, many studies showed that PWD have fewer sexual experiences, are less likely to have a sexual partner, and are less likely to engage in solo sexual activities (e.g., masturbation) [4–8]. In other words, their sexual citizenship is hampered [9–12].

PWD often face prejudice, such as being seen as asexual or hypersexual, and when they want to express their sexuality they encounter many barriers [13–16]. Solo sex is not always possible due to physical limitations or lack of sufficient knowledge about sexuality, it can also be challenging due to lack of privacy when having help at home [6, 17]. According to PWD themselves, facilitated sex, or sexual assistance, could be a way to enable them to express their sexuality [18, 19]. In this article, we speak of facilitated sex or sexual assistance/assistants to denote any sexual support for PWD or according to the terminology of the cited study, sex work(ers) to emphasize that these individuals or organizations identify with regular sex work, and sex care (work(ers)) when individuals or organizations explicitly state that they work within the care domain.

In some countries services offer the facilitation of sexual engagement of PWD (e.g., Sweden [20], the Netherlands [20], Denmark [21], Italy [22], Great Britain [23], Australia [24], Canada [25], and Japan [26]). For example, Bahner [20] reported how Swedish personal assistants helped their clients express their sexuality. Sexual assistance included "*Providing accessible information, fostering an environment which allows intimacy, offering and observing need for privacy, encouraging and enabling social interaction, the procurement of sexual goods, arranging paid-for sexual services, facilitation of masturbation or sexual intercourse with another party (undressing, handling of aids, positioning) and sexual surrogacy.*" (20 pp 2–3). However, policies to regulate sexual assistance were lacking, leading to ambiguity, differences in sexual assistance practice, and arbitrariness [20, 27]. In addition, sexual assistants may face stigma and disapproval from family or partner [19]; sex workers were confronted with stigma of support staff [28].

Several European countries have a form of legal sexual assistance for PWD, such as Switzerland, Germany, and the Netherlands [29]. These services offer paid sex with sex workers or sex care workers. The distinction between (or similarities of) sex work and sex care is debated [12, 30–32]. In the Netherlands, five service providers facilitate sex work or sex care [32]. Some providers explicitly identify themselves with regular sex work, such as prostitution or escort services, but specialize in providing paid sex for PWD. They follow Fritsch, Heynen, Ross, and van der Meulen [33] and others in their view that sex work has an important role in meeting the sexual needs of PWD, emphasizing that they are not caregivers and that sexual engagement should not be positioned in a care domain. In contrast, other organizations follow Earle [34, 35] and Aloni, Keren, and Katz [36] and see the sexual needs of PWD as part of other care needs (such as assistance with clothing, meals, etc.). They emphasize that sex care differs from sex work: "*Sex care is the facilitation and support of the (care) needs to shape intimacy and sexuality in people with one or more disabilities. With the aim of promoting, maintaining or compensating for desired sexual health and quality of life; if necessary in collaboration with involved* [care] *disciplines."* (37 pp.3). Although sex care is legal in the Netherlands, sex care organizations are

not allowed to employ sex workers and consequently intercede on a self-employed basis. Also, sex care is not a legitimate care discipline. Therefore, a professional competency profile for sex care workers was recently proposed [37], partly based on the principles of Partner Surrogate Therapy by Masters and Johnson [38]. This competence profile aims to contribute to the recognition of sex care as a legitimate care profession, as well as to the formulation of education and training goals. To date, no training exists in the Netherlands for sex care workers.

Little is known about the educational needs of sex care workers for PWD. Literature on Surrogate Partner Therapy emphasizes that surrogates must be knowledgeable about the disability and its resulting limitations [36]. Surrogates receive extensive training, including sex education, structured relaxation exercises, and sensual awareness exercises [39]. A comprehensive training for sexual assistants (up to 300 h) consisted of body-oriented sensual and sexual awareness exercises, in addition to other aspects such as knowledge about disabilities, disability-related sexuality and sexology, body language and eroticism, and ethics [22, 30]. Sexual assistant students have questions about transfer techniques and hygiene issues of clients [22].

Few studies addressed the motives for working as a sexual assistant. In an Italian study, would-be sexual assistants reported that they wanted to help PWD, and they wanted to allow PWD to have sexual experiences [19]. At the same time, they were motivated by earning extra income, and by the flexible working hours of the job. Money was also found as a motive in another study, in addition to helping PWD and out of sexual interest [40]. Another motive mentioned was supporting disability rights [30].

Recently, sex care for PWD has received political attention in the Netherlands. In May 2021, the short film 'Ada' premiered during the impact week 'Fabuch's Social Sex Show', in which the film was shown for five nights [41]. Ada depicts a day of a female sex care worker and was awarded 'De Noorderkroon' (best short film) and 'Noordster' (best Noordfilm). Each streaming of the film was followed by an online talk show in which sex workers/sex care workers, sex care clients, sex care organizations, sexologists, disability advocates, politicians and scientists (among others) debated the film and the importance of facilitating sexuality (with a focus on sex care) for PWD. In the slipstream of the impact week, a motion was amended by the Dutch House of Representatives and various parties worked together to come up with recommendations on what is needed to support PWD in the area of sexuality [32]. One of the ideas was to develop a training for sex care workers. Therefore, the current study aims to identify sex care workers' (perceived importance of) knowledge about relevant aspects of sex care, their training needs, motives to become a sex care worker and experiences.

Methods

Design

An online cross-sectional questionnaire study among sex care workers. The study was conducted from October to December 2021. The organizations involved approved the study (according to 27). The study was conducted in accordance with the 1964 Declaration of Helsinki and subsequent amendments [42].

Participants

All three organizations that identify themselves as *sex care* (as opposed to *sex work*) providers for PWD in the Netherlands participated in the survey. Each organization sent an invitation letter with a link to the online survey to the sex care workers they interceded. Because the survey was anonymous, a reminder letter was sent to all sex care workers two weeks later. At the beginning of the survey, participants were informed about the study and all gave their informed consent digitally.

Measurements

The survey was constructed in co-creation with one of the participating organizations. First, background characteristics were asked, including gender (female/male/other), age, having a partner/children (no/yes). If survey participants indicated they had a partner/children, they were asked if the partner/children knew they were working as a sex care worker and if the partner/children supported them in their work (no/yes).

Second, the questions referred to training and the time prior to starting as a sex care worker. 'Did you ever had training on sexuality and disability?' (no/yes); 'How did you learn about sex care?' (at work/via an acquaintance/via person who made use of sex care/via a sex care worker/via family member with need for sex care/via media (internet, magazine, TV)/other); and 'Did you ever have worked in the sex industry?' (no/yes).

Third, some general questions about working as a sex care worker were asked. 'How many years have you worked as a sex care worker?'; 'How many clients do you visit?' (one per year/one per quarter/one per month/two per month/one per week/two per week/three or more per week); 'Which clients do you visit?'(clients with a physical disability only/clients with a physical and intellectual disability/clients with an intellectual disability only/clients with autism or autism spectrum disorder/clients with a psychiatric disability/elderly without a disability/clients in forensic settings/other); 'Are you satisfied with working as a sex care worker?' (1 strongly dissatisfied – 5 strongly satisfied); 'Do you have a paid job in addition to working as a sex care worker?' (no/yes); and 'What sector do you work in?' (health and welfare/trade and services (not sex industry)/ICT/justice, security and public administration/agriculture, nature and fisheries/media and communication/education, culture and science/sex industry/engineering, manufacturing and construction/tourism, recreation and hospitality/transportation and logistics/other).

Fourth, based on the Knowledge, Comfort, Approach and Attitudes towards Sexuality Scale [43], the importance of having knowledge related to sexuality and sex care as a sex care worker and the current level of that knowledge were assessed by 16 items (of which seven items of Kendall et al. [43] on a 4-points Likert scale (1 very unimportant/I don't know nothing about this; 2 a little unimportant/my knowledge in this area is limited; 3 a little important/my knowledge in this area is sufficient; 4 very important/my knowledge about this is excellent). Three examples are 'The anatomy and function of the sexual organs'; 'ADL assistance with people with physical disabilities'; and 'Working with people with sexual orientations other than your own'. In addition, we asked 'Suppose a course with certification for sex care workers is developed, what would you want to learn during this course?' followed by nine items (no/yes) [44]. Examples are 'General knowledge about sexuality and sexual problems'; 'Diagnosis-specific knowledge about sexuality and sexual problems due to physical and/or

intellectual disabilities'; and 'Skills in handling assistive devices (e.g., hoist, incontinence equipment)'. Each item was followed by an open field to specify what participants would like to learn, and an overall open field to elaborate on other educational needs.

Fifth, four items addressed perceived stigma due to working as a sex care worker, using a 5-point Likert scale (1 totally disagree – 5 totally agree). 'If co-workers or my supervisor knew that I work as a sex care worker I could lose my job' and 'If my family/neighbors/best friends knew that I work as a sex care worker they would break contact'. Five statements addressed the motives to become a sex care worker, using the same 5-point Likert scale. Two examples are 'I felt there was too little attention for sexuality in supporting these clients' and 'I felt there was too little attention for people with disabilities in mainstream sex work'. Sex care workers' attitudes and experiences were addressed by 18 statements (four items based on), also using the same 5-point Likert scale. Examples are 'As a sex care worker, I offer loving sex to my clients'; 'As a sex care worker, I teach my clients to deal with sexuality'; 'As a sex care worker, I get paid well'. Participants were invited to make remarks in open fields of the questionnaire regarding stigma, motives for sex care work and experiences.

Analyses

Data were analyzed with IBM SPSS 25. To describe the sample frequencies and means (SD) or medians (IQR) (for skewed distributed variables (skewness > 1.25 or <-1.25)) were used. The importance of having knowledge of sexuality and aspects of sex care (outcome 1) and current knowledge levels (outcome 2) were reported in means (SDs). To test whether the importance of knowledge and current knowledge levels differed, the Paired T-test (sum scores) and the Related-Samples Wilcoxon Signed Rank Test (item scores) were applied. Educational needs (outcome 3) were expressed in frequencies. For these three outcomes, reliability was tested (Cronbach's alpha) and sum scores were computed. In addition, to examine whether the level of experience as a sex care worker was related to the three outcomes, four background characteristics were used (number of years working in sex care; having had training in sexuality and disability; having previously worked in the sex industry; and frequency of client visits) (Spearman's rho (nominal/ordinal/skewed scale by scale) or Pearson r (scale by scale)). Perceived stigma, motives to become a sex care worker and attitudes and experiences of sex care workers were shown in both means (SDs) and frequencies ((strongly) agree). The answers in the open fields of the questionnaire consisted of short phrases (quotes) and were merged in an excel file. The phrases were thematically categorized as a deepening of the quantitative results. To ensure anonymity of the participants, the quotes were presented with gender only and not with age.

Results

Sample

A total of 56 sex care workers were invited to participate, of whom 29 (52%) responded. The response rate varied by organization (50–60%). The vast majority were female (85%), the sex care workers had a mean (SD) age of 46.4 (8.0) years and 81% had a job in addition to sex care (Table 1). Fifteen participants (56%) currently had a partner and 82% had children;

almost all partners were informed about and supported their work in sex care. Children were less likely to be informed (29%). Participants worked as sex care workers for a median of 4.0 (IQR = 2.0-7.8) years and visited clients with various disabilities. The majority (52%) visited two or more clients per week. Three participants reported being very dissatisfied with working as a sex care worker, 58% were very satisfied. About half (43%) had previously worked in the sex industry.

Knowledge about sexuality and aspects of sex care and educational needs

Participants were asked how important it was to have knowledge about sexuality and various aspects of sex care (Cronbach's alpha 0.84; mean (SD) 58.1 (5.1); theoretical range 16–64) (Table 2). The mean scores of all 16 items were 3.3 or higher, indicating that all aspects were generally considered important to very important. The four most important aspects were dealing with inappropriate behavior during an appointment, anatomy and function of genitalia, communication during an appointment with a client, and guiding clients on what is appropriate behavior during an appointment. Overall, participants reported having good levels of knowledge about sexuality, and how to work with and support their clients during visits (Cronbach's alpha 0.92; mean (SD) 49.2 (7.1); theoretical range 16–64). For most items, participants' mean scores were higher than 3.0, meaning that their knowledge was generally considered adequate to excellent. Current knowledge levels about psychiatric problems, working with clients with autism or autism spectrum disorder, problems associated with physical limitations, and reimbursement options for sex care had mean scores lower than 3.0, generally indicating that participants felt less confident about these topics.

The sum scores of importance of knowledge and current level of knowledge were significantly different ($t = 6.3$, $df = 25$, $p < .001$), indicating that participants' reported importance was higher than their current level of knowledge (Table 2). This difference was seen in almost all items (p's $< .05$).

Participants reported different educational needs (Cronbach's alpha 0.89, mean (SD) = 5.5 (3.4); theoretical range 0–10) (Table 3). The three most commonly reported were general knowledge about sexuality and sexual problems (77%), diagnosis-specific knowledge about sexuality and sexual problems due to physical and/or intellectual disabilities (77%), and skills in dealing with client problem behaviors and/or emotional disinhibition (73%). Skills in reporting on the client visit (46%) and skills in dealing with the client's professional caregivers (50%) were reported least frequently. Table 4 summarizes the training needs reported in the open fields (quotes included in the text below are not repeated in the table). Communication skills were frequently mentioned, referring to coping with limitations, reporting to caregivers, and client problem behavior/inhibition. On the latter, one participant said the following: "*Some clients can be slowed down a bit, they want everything done in 5 minutes.*" (Female). Regarding general entrepreneurial skills, participants mentioned tax issues such as VAT and tax return. Some preferred to have an accountant: "*For example an accountant through the organization, many accountants do not want to work with sex workers I know from experience.*" (Female). One participant (gender not reported) wanted to learn more about sex care advocacy: "*I would like to gain more knowledge about general entrepreneurial skills, such as getting your own professional code. How can we present ourselves to the outside world in such a way that our work is accepted by society?*". Other educational needs referred to keeping boundaries, lifting techniques, safety issues and how to stay physically

Table 1 Background characteristics of sex care workers in the Netherlands (n=29)

Characteristics	n valid	Sample
Gender (n (%))	27	
Female		23 (85)
Male		3 (11)
Other		1 (4)
Age (mean (SD))	28	46.4 (8.0)
Having a partner (n (%))	27	15 (56)
Partner knows of working as a sex care worker (n (%))	15	13 (87)
Partner supports working as a sex care worker (n (%))	13	13 (100)
Having children (n (%))	27	22 (82)
Children know of working as a sex care worker (n (%))	21	6 (29)
Children support working as a sex care worker (n (%))	6	5 (83)
Ever had training on sexuality and disability (n (%))	28	5 (18)
Learnt about sex care (n (%))	29	
Via my work		5 (17)
Via an acquaintance		2 (7)
Via a person who made use of sex care		2 (7)
Via a sex care worker		3 (10)
Via family member with need for Sex Care		5 (17)
Via media (internet, magazine, TV)		8 (28)
Other		4 (14)
Having worked in the sex industry in the past (n (%))	28	12 (43)
Number of years working as a sex care worker (median (IQR))	28	4.0 (2.0-7.8)
Frequency of client visits (n (%))	25	
One per month		2 (8)
Two per month		3 (12)
One per week		7 (28)
Two per week		3 (12)
Three or more per week		10 (40)
Clients visited (n (%)) (multiple options)	25	
Clients with a physical disability only		18 (72)
Clients with physical and intellectual disability		25 (100)
Clients with an intellectual disability only		17 (68)
Clients with autism or autism spectrum disorder		23 (92)
Clients with a psychiatric disability		21 (84)
Elderly without a disability		16 (64)
Clients in forensic settings		7 (28)
Satisfaction with working as sex care worker (n (%))	26	
Strongly dissatisfied		3 (11)
Satisfied		8 (31)
Strongly satisfied		15 (58)
Having a paid job in addition to working as a sex care worker (n (%))	26	21 (81)
Work setting (n (%))	19	
Healthcare and welfare		14 (74)
Trade and services (not sex industry)		4 (21)
Agriculture, nature and fisheries		1 (5)

Table 2 Importance of having knowledge and current knowledge levels reported by sex care workers (n = 26)

Knowledge sum scores and items (mean (SD))	Importance of knowledge	Current level of knowledge	*p*
Sum score	58.1 (5.1)	49.2 (7.1)	<0.001
Dealing with inappropriate behavior during an appointment	4.0 (0.0)	3.0 (0.7)	<0.001
The anatomy and function of the sexual organs	3.9 (0.4)	3.5 (0.6)	0.002
Communication during an appointment with a client	3.9 (0.3)	3.4 (0.6)	0.003
Guiding clients on what is appropriate behavior during an appointment	3.9 (0.3)	3.2 (0.7)	<0.001
Positions when having sex with a client	3.8 (0.6)	3.5 (0.6)	0.052
Common problems associated with physical limitations	3.8 (0.4)	2.9 (0.6)	<0.001
Psychiatric disorders and concomitant issues	3.7 (0.7)	2.8 (0.6)	<0.001
Changes in the perception of one's sexual identity as a result of a disability (self-esteem, body perception and sexuality)	3.7 (0.7)	3.1 (0.6)	0.003
Dealing with incontinence issues during sex with a client	3.7 (0.6)	3.0 (0.8)	0.006
Working with clients with autism or autism spectrum disorder	3.7 (0.5)	2.9 (0.6)	0.001
ADL assistance with people with physical disabilities	3.7 (0.5)	3.2 (0.8)	0.022
Guiding clients on what is appropriate behavior outside of the appointment	3.5 (0.8)	3.1 (0.7)	0.022
Assistive devices and medications to help you achieve an erection	3.5 (0.7)	3.0 (0.7)	0.007
Working with people with sexual orientations other than your own	3.4 (0.8)	3.3 (0.6)	0.675
Working with assistive devices (e.g., hoist, wheelchair, incontinence equipment)	3.4 (0.6)	3.0 (0.9)	0.79
Reimbursement options for sex care for clients	3.3 (0.9)	2.2 (0.7)	<0.001

fit. "*Very important to me: defining your own boundaries, how to do that. Also, you often have strange sex positions and how do you keep an eye on your body when doing that.*" (Female).

Sex care workers' level of experience and knowledge and educational needs

The sum score of importance of knowledge did not correlate with participants' level of experience as a sex care worker (Spearman's rho's = .09-.33; p's = .10-.69). However, some

Table 3 Educational needs of sex care workers (n = 26)

Educational needs sum score (mean (SD)) and items (n (%))	Sample
Sum score	5.5 (3.4)
General knowledge about sexuality and sexual problems	20 (77)
Diagnosis-specific knowledge about sexuality and sexual problems due to physical and/or intellectual disabilities	20 (77)
Skills in dealing with client problem behaviors and/or emotional disinhibition	19 (73)
Skills in coping with physical and/or mental disabilities	16 (62)
Skills in handling assistive devices (e.g., hoist, incontinence equipment)	15 (60)
General knowledge about STDs, infectious diseases and preventive measures	15 (58)
General entrepreneurial skills	14 (54)
Skills in dealing with the client's professional care givers	13 (50)
Skills in reporting on the client visit	12 (46)
Something else	6 (23)

associations appeared on item level. Those who worked in sex care for a longer period of time felt it was more important to know about different positions when having sex with a client (Spearman's rho = .51; p = .008) and about guiding clients about what is appropriate behavior outside of the appointment (Spearman's rho = .48; p = .013). Those who had not had training on sexuality and disability felt it was more important to have knowledge about reimbursement options for receiving sex care (Spearman's rho=-.45; p = .020). Those who had previously worked in the sex industry were more likely to say that knowledge about how to deal with incontinence problems during sex with a client (Spearman's rho = .45; p = .020) and knowledge about tools or medications to get an erection (Spearman's rho = .41; p = .040) were important. Conversely, they were less likely to say that knowledge about communicating with a client was important (Spearman's rho = -.39; p = .049).

Also the sum score of current knowledge levels did not correlate with the sex care workers' level of experience (Spearman's rho's = .12-.29; p's = .18-.56), although few associations on item level were found. Those who were sex care worker for a longer period of time knew more about common problems associated with physical limitations (Spearman's rho = .44; p = .024). Participants who had received training on sexuality and disability knew more about how to work with assistive devices (Spearman's rho = .44; p = .026). Lastly, those with more frequent client visits knew better what common problems were associated with physical limitations (Spearman's rho = .44; p = .033) and how to deal with client's inappropriate behavior during an appointment (Spearman's rho = .46; p = .023).

The sum score of educational needs did not associate with the sex care workers' level of experience (Spearman's rho's = .01-.39; p's = .06-.98). On item level, participants who less frequently visited clients more often reported they wanted to learn about reporting on the client visit (Spearman's rho = -.42, p = .043).

Stigma, motives for sex care work and attitudes and experiences

Participants felt relatively little stigma because of being a sex care worker (means 2.4-3.0; (strongly) agree 15–25%), with feeling most confident about it with close friends (Table 5). In addition, few participants mentioned that client's professional caregivers were reluctant

Table 4 Spontaneous reported educational needs by sex care workers

Educational needs	Open remarks
General knowledge about sexuality and sexual problems	• *I have gained enough information myself. As far as sexual problems are concerned, some common ones can be highlighted. So we can take that into account. Partly because of our approach to the client. Very important. Furthermore, we get a case to prepare us and there is a necessary description. Perhaps this more elaborate with problem description mentioned plus tips how to deal with it.* • *Since I have never worked with people with disabilities, it is helpful to have some prior knowledge of what problems may arise.* • *What someone with a physical and/or mental disability can suffer from and what can get in the way of intimacy. I am very happy with the internet myself but still.* • *Some general, common complaints such as impotence, STDs etc.* • *Erection problems, function of sexual organs, pathology of sexual organs.* • *Learning to know/sense what a client is feeling and how those wishes will be.*
Diagnosis-specific knowledge about sexuality and sexual problems due to physical and/or intellectual disabilities	• *Learning about intellectual disabilities on all fronts.* • *Communication skills: How to deal with intellectual disability.* • *Clients with Multiple Sclerosis, Paralyses. How best to act or take into account.* • *Basic training on how someone's limitations affect sexuality.* • *The impact of a specific diagnosis on experiencing sexuality, and how to deal with it.*
Skills in dealing with client problem behaviors and/or emotional disinhibition	• *How then can I provide safety for the client as well as myself.* • *Crucial to be able to guide the client well and to guard one's own boundaries.* • *How to deal with problem behavior and disinhibition, so that it does not interfere with the experience of sexuality?* • *How to deal with grief, without the client becoming too dependent on you.* • *How to act in situations where a client is triggered and in this way calm down the client.* • *Especially knowledge about psychiatry.*
Skills in coping with physical and/or intellectual disabilities	• *Conversation techniques.* • *Acquiring knowledge about physical and intellectual disabilities, and using this knowledge during the appointment to make the appointment as pleasant as possible for the client. Skills in the areas of conversation, touch, and attitudes during sex.* • *What limitations are common in practice and how do you best handle them? Best practices.* • *What possibilities exist for the client with spasm, deafness, blindness, poor speech?*
Skills in handling assistive devices (e.g., hoist, incontinence equipment)	• *ADL assistance and the tools that are available to prevent putting too much strain on one's own body by, for example, heavy lifting.* • *Lifting techniques, helping to dress and undress, movement/posture in bed.* • *I personally think everyone should stick to their own business. I have not been hired to operate a hoist. There is a special training for that and we should not want to do that. I always ask the caregiver to operate it. This is extremely important to pass on to the caregivers to ensure the safety of the client. Nothing is as unprofessional as a caregiver trying to do it and then something goes completely wrong. So just stay away from it and leave the work to the people who know about it.* • *We are not allowed to work with hoist for insurance reasons, even if you do this every day at your other work, but if we could get a certificate for this work it would be very useful. This is because foreplay can then take place while the client is still in the wheelchair and you can choose when to undress someone, for example.* • *Dealing with other sexual aids such as penis pump, various condoms, and other sex toys to support appointment.*
General knowledge about STDs, infectious diseases and preventive measures	• *I would like to learn more about the contagiousness of viruses and bacteria, and how to prevent infection. Preventive measures to prevent infectious diseases and contamination through bodily contact.* • *What STDs are there, how to recognize them, how to protect yourself and the client.*

Table 4 (Continued)

Educational needs	Open remarks
General entrepreneurial skills	• *General skills, my knowledge in this area is limited.* • *Securing business agreements.* • *Administration, good documentation of income, expenses, costs, tax etc.* • *Help with registration, tax matters, bookkeeping, insurance.*
Skills in dealing with the client's professional care givers	• *Know that if there are problems in this area, that [name sex care organization] can mediate. This should be part of the training.* • *How to discuss the theory with the client in preparation for the practical experience with the sex care worker.* • *To inform caregivers without violating the privacy of the client.*
Skills in reporting on the client visit	• *I can already report quite well, but in the training there should be attention for what is relevant and what is not, and privacy aspect.* • *Objective reporting is important for quality.* • *Type of methodology for reporting. What not to report or what to report.*
Something else	• *How to deal with ethical dilemmas or when client falls in love.* • *I would like all of the above to be given as some kind of introductory training. Massage techniques such as regular, erotic and erogenous/genital massages.* • *It is incredibly beautiful and important work. My wish is that the government will recognize this. It prevents so many problems, both for the client and for the environment.*

to sex care workers. "*I find it more difficult to talk to caregivers than to clients but I think it usually goes well. My experience is that it is precisely on the side of the caregivers that it is experienced as somewhat uncomfortable.*" (Female). Another female participant met negative attitudes of professional caregivers: "*Not everyone supports our work, not even in healthcare. I have experienced disparaging behavior or being told* [by a caregiver]: *'I don't want to have anything to do with that.'*"

Concerning their motives for being a sex care worker, lack of attention for sexuality in PWD and liking to help PWD to experience sexuality were most common (means 4.4; (strongly) agree 92–96%) (Table 5).

Important motives for doing sex care work referred to being able to meet sexual needs of clients. As one said: "*Through contact with a friend with a physical disability I realized that it can be difficult or impossible to find a partner if you have one or more disabilities.*" (Female). Others mentioned that there is a lack of attention for clients' sexuality. Some said that they were motivated by how clients personally developed once they received sex care. "*Teaching clients new skills.*" (Female), and "*It is very important and healing and a positive experience* […]" (Female). Participants found that providing sex care was meaningful. "*I knew from myself that I would be able to separate private sex and sex as care giving. And I love to make people feel good with my body.*" (Female). Another female said: "*Sometimes you find out that you are completely at your place. This is evident from the feedback from clients but especially from the fact that I can be myself. My free spirit combined with my life wisdom comes into its own here. By filling their needs, my battery is recharged. And then you also get paid for it. Super anyway. Win-win for both parties.*"

Overall, participants reported positive attitudes and experiences concerning sex care. Participants felt valuable for, respected by and safe with their clients, and said they contributed to the lives of their clients (means 4.1–4.7; (strongly) agree 81–100%) (Table 5). About one third (mean 3.0; (strongly) agree 31%) found it important to also enjoy themselves when having sex with a client, a small minority (mean 2.3; (strongly) agree 13%) was sexually attracted to PWD.

Table 5 Perceived stigma, motives for becoming a sex care worker and attitudes and experiences of sex care workers (n=27)

Variables	n valid	Sample	
		mean (SD)	n (%) (strongly) agree
Stigma			
If co-workers or my supervisor would know that I'm a sex care worker, I could lose my job	20	3.0 (1.0)	5 (25)
If my neighbors would know I'm a sex care worker they would break contact	20	3.0 (1.1)	5 (25)
If my family would know I'm a sex care worker they would break contact	20	2.8 (1.2)	5 (25)
If my best friends would know I'm a sex care worker they would break contact	20	2.4 (1.0)	3 (15)
Motives for becoming a sex care worker			
I felt there was too little attention for sexuality in supporting these clients	24	4.4 (0.7)	23 (96)
I liked to help people with disabilities to experience sexuality	25	4.4 (0.6)	23 (92)
I wanted to develop myself as a professional	23	4.2 (0.7)	20 (87)
I felt there was too little attention for people with disabilities in mainstream sex work	20	4.2 (0.7)	17 (85)
I wanted to develop myself as a person	24	4.2 (0.7)	20 (83)
Attitudes and experiences			
As a sex care worker, I do important work	27	4.7 (0.5)	27 (100)
As a sex care worker, I offer loving intimacy to my clients	27	4.7 (0.5)	27 (100)
As a sex care worker, I teach my clients to deal with sexuality	27	4.5 (0.5)	27 (100)
It gives me satisfaction that a client experiences sexuality	26	4.5 (0.5)	26 (100)
As a sex care worker, I offer loving sex to my clients	27	4.5 (0.6)	26 (96)
Sex care should be reimbursed for clients	26	4.5 (0.7)	23 (88)
I am well supervised by my organization in my work	26	4.4 (0.6)	25 (96)
My work as a sex care worker is respected by my partner	14	4.4 (0.8)	12 (86)
Sex care is the only way for my clients to experience sexuality	26	4.2 (0.7)	23 (88)
As a sex care worker, I feel respected by my clients	26	4.2 (0.7)	22 (85)
As a sex care worker, I feel safe with my clients	26	4.1 (0.7)	21 (81)
Sex care workers receive appreciation from clients' caregivers	27	3.9 (1.0)	17 (63)
When I visit a new client I know what to expect	26	3.8 (0.7)	18 (69)
As a sex care worker, I get paid well	27	3.7 (0.8)	17 (63)
My work as a sex care worker is respected by those close to me	17	3.4 (0.9)	9 (53)
It is important for me that I also enjoy when I am having sex with my clients	26	3.0 (1.0)	8 (31)
As a sex care worker, I would like to have more say in who my client is	26	2.7 (0.8)	3 (12)
I am sexually attracted to people with disabilities	24	2.3 (1.0)	3 (13)

Most participants were positive about their work, although some also noted negative experiences. "*Many male clients I visit want to get into bed as soon as I enter. Personally, I prefer to talk for a while to build up quietly. Female clients are more open to having a chat first.*" (Male). Another had encountered very demanding clients. "*Clients who have other (high) expectations that you cannot fulfill, requests that you cannot/will not fulfill. I have also experienced being treated in a very unfriendly manner by a client.*" (Female). Nevertheless,

participants valued their work because sex care contributed to the clients' sexual citizenship. "*Clients are confronted all day with the fact that they have a disability. When they have sex, they do things that everyone else does and then they feel part of society, like a 'normal' person who does normal things and who can also talk about this aspect of life.*" (Female). A male participant stressed the importance of sex care: "*Intimacy and sex care especially for this target group is essential. The clients feel more human, less stressful, sexual harassment by clients of healthcare professionals will decrease, less aggression, less medication.*" Participants found it rewarding that sex care contributed to clients' personal development. One participant noted: "*So cool to see what it does with clients. Problem behavior reduces or disappears.*" (Female). Another claimed: "*Through sex care, clients grow in all areas, not just sexually. Self-confidence grows which makes them feel better in all areas.*" (Female).

Own enjoyment with being intimate with clients appeared to be a controversial subject. One female participant remarked: "*The question about sexual attraction to clients is inappropriate and irrelevant. As a sex care worker, if you yourself are aroused by people with disabilities* […] *you are very unfit to be a sex care worker. Morally, this is not correct. You should not be in it for your own sexual gain because then there is a conflict of interest, you are serving the needs of your client, not yourself.*" Another female participant nuanced enjoyment: "*I enjoy the work that I do, but that is different from enjoying making love to a client. I also enjoy helping a client in a nursing home or home care with, for example, grooming, eating, dressing, toileting, etc.*" However, another said that her own sexuality (partly) played a role. "*I was cheating for years, did not know what caused it and in retrospect I have missed the intimacy/affection all my life. With this work I found out the truth, I am now a happy person to be able to do this work for the elderly and disabled people.*"

Discussion

The 29 sex care workers surveyed indicated a high level of importance to knowledge about various aspects of sexuality and sex care and generally reported good – but slightly lower and varying – current knowledge levels about these aspects. In general, participants did experience little stigma, although some reported negative experiences. Most participants were personally or professionally familiar with PWD and noted that sex care contributed to their clients' sexual citizenship. This is consistent with the literature that sexual assistants have a strong connection to disability rights, and that most are close to PWD either professionally or personally [30]. Important motives for sex care work included the lack of attention to sexuality support among clients with disabilities and wanting to contribute to sexual citizenship of PWD. Sex care workers were generally positive about their work.

Although their current level of knowledge was good, sex care workers felt the importance of this knowledge was even greater. The knowledge included general aspects of sexuality as well as aspects related to sex care work. Sex care workers were less confident in working with clients with psychiatric problems or autism spectrum disorder and with clients with secondary problems due to physical disabilities. Reported educational needs mirrored these findings: participants wanted to learn about both general and disability-related sexuality and sexual problems and how to deal with problem behaviors and/or emotional disinhibition. Overall, sex care workers' experience levels showed little correlation with the importance of knowledge, current knowledge level, and educational needs.

Some participants reported that learning to avoid physical strain was important, referring to both challenging body positions and transfer techniques; the latter was also found by Morales [22]. In addition, the importance of setting boundaries was reported, which is consistent with other studies [30, 45]. One specific form of setting boundaries concerned the acceptability of one's own pleasure while having sex with a client. Participants held a variety of opinions, from totally unacceptable on the one hand to saying that one's own sexual feelings were what drove one to start as a sex care worker on the other. In our sample, 31% said that own pleasure was important, pleasure did not mean sexual enjoyment per se. This is a controversial point in the literature. Garofalo Geymonet (45 pp.4) reported on a sexual assistance organization: "[sexual assistants] *tend to embrace a discourse of reciprocity with the clients, including around aspects of pleasure. Key activists in the field go so far as thinking that sexual assistants should be able to experience sexual pleasure and even orgasms with their clients. Obviously this question is very contested. In any case, issues of intimacy, pleasure, boundaries, and power (im)balances are at the centre of the collective training and inter-vision sessions.*" The sexual assistants seemed to have a 'liberal sexual identity': "[...] *due to having disabled partners, or practicing BDSM, tantric sex, and so on.*" (30 pp.218) or being non-monogamous and swingers [45]. Another study reported that 23% of sexual assistants surveyed were sexually attracted to PWD and 33% started as sexual assistants because of their sexual interest [40].

The controversy seems to be related to the discussion of whether this kind of sexual assistance is practiced from a care perspective or whether it is regular sex work (see also 40). Some organizations strongly oppose the view that sex care is equivalent to sex work [32,46]. They see themselves as care organizations because they have established protocols and guidelines, and they visit clients within long-term care facilities to meet their needs for sexual engagement [47, 48]. Also, the proposed professional competency profile for sex care workers states that reporting on client visits should be part of the professional competencies [37]. Care ethics and client safety are paramount, therefore any association with regular sex work should be avoided. In addition, Dutch sex care organizations strive for reimbursement for sex care and they call for sex care to be recognized as a legitimate health care profession. Therefore, the possible sexual attraction of sex workers to PWD is a controversial issue. The sexual interest of sex care workers can put clients at risk because the sexual needs of clients might not be the starting point, with possible sexual exploitation as the ultimate consequence [40]. Interestingly, men with disabilities who meet with paid sex workers view these encounters as special precisely because their bodies are not seen and touched in a medical context. The experience involves not only their own pleasure, but also the ability to provide pleasure [25]. So the discussion of whether sexual assistance is sex care, sex work, or perhaps a middle ground or something else completely, is not only important for the positioning of sex care as a profession. This discussion is also about the position of PWD, how they can shape their sexual citizenship and how they want to be supported in this, and about the level of reciprocity. The discussion is not only about providing sex care, but also about the underlying needs for sex (care) and how this gives meaning to PWD' sexual citizenship. The latter relates more to sexual assistance from a more disability rights-oriented perspective ([30]).

Motives for starting as a sex care worker included the lack of attention to sexuality for PWD and that they liked supporting PWD to experience sexuality. Further, participants found it rewarding and recognized that their clients were making progress as a result of sex care [19]. Other known motives include earning extra money [19, 40, 45]. Most participants

worked in a health or welfare setting, and some had previously worked in the sex industry, which is consistent with a previous study [45].

Strengths and limitations

Although the number of participants was limited, a strength of the study was that all organizations that facilitate sex care participated in the survey and the response rate from sex care workers was high (52%). Nevertheless, the sample size hinders drawing firm conclusions, also partly due to the varying missing values in the responses. A strength of the study is that we included participants of whom 52% had at least two client visits per week. While this might suggest that we mostly included sex care workers who spent a relatively large amount of time in sex care, this number is consistent with the experience of the three organizations. The frequency of client visits was hardly associated with training needs and level of knowledge. This means that even the more experienced sex care workers can improve their knowledge and skills. Third, we did not identify clients' needs and expectations, so we do not know if preferences and experiences of clients indicate different training needs of sex care workers.

Conclusion

Sex care workers showed a high level of knowledge about sexuality and important aspects of sex care. However, the current level of knowledge was lower than the reported importance of having this knowledge as a sex care worker, which gives room for the formulation of training goals. The recently proposed professional competency profile for sex care workers [37], together with the educational needs found in this study, can be helpful in developing such training. In addition to the various knowledge and skill needs, the training should pay attention to discovering and setting boundaries and to providing a safe space for reflection on one's own body experience and personal ethics. The perspective of sex care clients could also provide a valuable contribution to the development of the training and to the discussion on the positioning of sexual assistance within the care or sex work domain.

Acknowledgements We thank the sex care workers for their participation in the study. We acknowledge Loet Berkelmans (FleksZorg), Ursula Blaak (Need2Care) and Monique Bijkerk (Stichting Snoezelzorg) for their commitment to this study. Special thanks for Loet Berkelmans and Sofie van den Haak for their constructive comments while drafting the questionnaire. The authors have no relevant financial or non-financial interests to disclose.

Authors' Contribution Sander Hilberink contributed to the study conception, design, material preparation and data collection. Analyses were performed by Sander Hilberink and Heleen van der Stege. Ymke Kelders performed an additional literature search. The first draft of the manuscript was written by Sander Hilberink. All authors interpretated the results, commented on previous versions of the manuscript, read and approved the final manuscript.

Open Access This article is licensed under a Creative Commons Attribution 4.0 International License, which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if changes were made. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit http://creativecommons.org/licenses/by/4.0/.

References

1. Kaufman, M., Silverberg, C., Odette, F.: The Ultimate Guide to Sex and Disability: For All of Us Who Live with Disabilities, Chronic Pain and Illness. Cleis Press, San Fransisco (2007).
2. World Health Organization & United Nations Population Fund.: (2009). https://apps.who.int/iris/handle/10665/44207. Accessed 04 April 2022
3. Gianotten, W.L.: The (Mental) health benefits of sexual expression. In: Lew-Starowicz, M., Giraldi, A., Krüger, T.H.C. (eds.) Psychiatry and sexual medicine, pp. 57–70. Springer, Cham (2021).
4. Bathje, M., Schrier, M., Williams, K., Olson, L.: The Lived Experience of Sexuality Among Adults With Intellectual and Developmental Disabilities: A Scoping Review. Am. J. Occup. Ther. 75(4), 7504180070 (2021). https://doi.org/10.5014/ajot.2021.045005
5. Namatovu, F., Häggström Lundevaller, E., Vikström, L.: The impact of disability on partnership formation in Sweden during 1990–2009. The History of the Family. 25(2), 230–245 (2020). https://doi.org/10.1080/1081602X.2019.1692054
6. McCarthy, M., Thompson, D.: Sexuality and Learning Disabilities: A handbook. Pavilion Publishing, Brighton (2010).
7. Wiegerink, D.J., Roebroeck, M.E., Donkervoort, M., Stam, H.J., Cohen-Kettenis, P.T.: Social and sexual relationships of adolescents and young adults with cerebral palsy: a review. Clin. Rehabil. 20(12), 1023–1031 (2006). https://doi.org/10.1177/0269215506071275
8. Wiegerink, D.J., Roebroeck, M.E., Donkervoort, M., Cohen-Kettenis, P.T., Stam, H.J., Transition Research Group South West Netherlands: Social, intimate and sexual relationships of adolescents with cerebral palsy compared with able-bodied age-mates. J. Rehabil Med. 40(2), 112–118 (2008). https://doi.org/10.2340/16501977-0137
9. Shakespeare, T., Gillespie-Sells, K., Davies, D.: Untold Desires: The Sexual Politics of Disability. Cassell, London/New York (1996).
10. Shakespeare, T.: Disabled sexuality: Toward rights and recognition. Sex. Disabil. 18(3), 159–166 (2000). https://doi.org/10.1023/A:1026409613684
11. Siebers, T.: Disability Theory. University of Michigan Press, Ann Arbor (2008).
12. Bahner, J.: Sexual citizenship and disability: Understanding sexual support in policy, practice and theory. Routledge (2019).
13. Hunt, X., Carew, M.T., Braathen, S.H., Swartz, L., Chiwaula, M., Rohleder, P.: The sexual and reproductive rights and benefit derived from sexual and reproductive health services of people with physical disabilities in South Africa: beliefs of non-disabled people. Reprod. Health Matters. 25(50), 66–79 (2017). https://doi.org/10.1080/09688080.2017.1332949
14. Brown, H.: 'An ordinary sexual life?': a review of the normalisation principle as it applies to the sexual options of people with learning disabilities. Disabil. Soc. 9(2), 123–144 (1994). https://doi.org/10.1080/09687599466780181
15. Esmail, S., Darry, K., Walter, A., Knupp, H.: Attitudes and perceptions towards disability and sexuality. Disabil. Rehabil. 32(14), 1148–1155 (2010). https://doi.org/10.3109/09638280903419277
16. Correa, A.B., Castro, Ã., Barrada, J.R.: Attitudes Towards the Sexuality of Adults with Intellectual Disabilities: A Systematic Review. Sex. Disabil. 1–37 (2021). https://doi.org/10.1007/s11195-021-09719-7
17. Morales, E., Gauthier, V., Edwards, G., Courtois, F.: Masturbation Practices of Men and Women with Upper Limb Motor Disabilities. Sex. Disabil. 34(4), 417–431 (2016). https://doi.org/10.1007/s11195-016-9445-9
18. Browne, J., Russell, S.: My home, your workplace: people with physical disability negotiate their sexual health without crossing professional boundaries. Disabil. Soc. 20(4), 375–388 (2005). https://doi.org/10.1080/09687590500086468
19. Gammino, G.R., Faccio, E., Cipolletta, S.: Sexual assistance in Italy: an explorative study on the opinions of people with disabilities and would-be assistants. Sex. Disabil. 34(2), 157–170 (2016). https://doi.org/10.1007/s11195-016-9435-y
20. Bahner, J.: Risky business? Organizing sexual facilitation in Swedish personal assistance services. Scand. J. Disabil. Res. 18(2), 164–175 (2015). https://doi.org/10.1080/15017419.2015.1063540
21. Socialstyrelsen: Seksualitet på Dagsordenen: En håndbog om Professionel støtte til voksne med Funktionsnedsættelse [Sexuality on the Agenda: A Handbook for Professional Support to Adults with Disabilities]. Socialstyrelsen, Denmark (2012).
22. Morales, E., Quattrini, F., Auger, C., Gauthier, V.: What Sexual Assistants Want and Need: Creating a Toolkit and New Solutions to Help Them Better Perform Their Work with Individuals with Disabilities. Sex. Disabil. 38(1), 19–29 (2020). https://doi.org/10.1007/s11195-019-09614-2
23. TLC Trust.: Welcome to the TLC Trust. Online. Available from: http://www.tlc-trust.org.uk/. Accessed 27 April 2022

24. Touching Base.: Touching Base. Online. Available from: http://www.touchingbase.org/. Accessed 27 April 2022
25. Liddiard, K.: 'I never felt like she was just doing it for the money': Disabled men's intimate (gendered) realities of purchasing sexual pleasure and intimacy. Sexualities. 17(7), 837–855 (2014). https://doi.org/10.1177/1363460714531272
26. Sakairi, E.: Medicalized pleasure and silenced desire: sexuality of people with physical disabilities. Sex. Disabil. 38(1), 41–56 (2020). https://doi.org/10.1007/s11195-020-09618-3
27. Bahner, J.: The power of discretion and the discretion of power: personal assistants and sexual facilitation in disability services. Vulnerable Groups & Inclusion. 4(1), 20673 (2013). https://doi.org/10.3402/vgi.v4i0.20673
28. Wotton, R.: Sex workers who provide services to clients with disability in New South Wales, Australia. Master thesis. University of Sydney (2016). https://ses.library.usyd.edu.au/bitstream/handle/2123/16875/Wotton_RW_thesis.pdf;jsessionid=133D9732D3536948AF11F893182EA62D?sequence=1. Accessed 30 April 2022
29. Pinho, A.R., Oliveira, J.M.D., Nogueira, C.: Sex workers' narratives about clients with disabilities: can training improve. Sex. health Portugal?. 29(3), e180992 (2020). https://doi.org/10.1590/S0104-12902020180992
30. Garofalo Geymonat, G.: Disability rights meet sex workers' rights: the making of sexual assistance in Europe. Sex. Res. Soc. Policy. 16(2), 214–226 (2019). https://doi.org/10.1007/s13178-019-0377-x
31. Wotton, R., Isbister, S.: Similarities and differences between sexual surrogacy, sex work and facilitated sexual assistance. J. Sex. Med. 14(5), e252–e253 (2017). https://doi.org/10.1016/j.jsxm.2017.04.249
32. Kool, J., Kelders, Y., van Kampen, L.: Faciliteren van seksualiteit en intimiteit voor mensen met een beperking: een inventarisatie van de ondersteuningsmogelijkheden in Nederland. [Facilitating sexuality and intimacy for people with disabilities: an inventory of support options in the Netherlands]. Stichting Tiresias/Rutgers, expertise centrum seksualiteit, the Netherlands (2021). https://open.overheid.nl/repository/ronl-b90b3897e791c116bc0eff97d775f1a168e75505/1/pdf/faciliteren-van-seksualiteit-en-intimiteit-voor-mensen-met-een-beperking-een-inventarisatie-van-de-ondersteuningsmogelijkheden-in-nederland.pdf. Accessed 29 April 2022
33. Fritsch, K., Heynen, R., Ross, A.N., van der Meulen, E.: Disability and sex work: developing affinities through decriminalization. Disabil. Soc. 31(1), 84–99 (2016). https://doi.org/10.1080/09687599.2016.1139488
34. Earle, S.: Facilitated sex and the concept of sexual need: disabled students and their personal assistants. Disabil. Soc. 14(3), 309–323 (1999). https://doi.org/10.1080/09687599926163
35. Earle, S.: Disability, facilitated sex and the role of the nurse. J. Adv. Nurs. 36(3), 433–440 (2001). https://doi.org/10.1046/j.1365-2648.2001.01991.x
36. Aloni, R., Keren, O., Katz, S.: Sex therapy surrogate partners for individuals with very limited functional ability following traumatic brain injury. Sex. Disabil. 25(3), 125–134 (2007). https://doi.org/10.1007/s11195-007-9047-7
37. van den Haak, S., Berkelmans, L.: Aanzet tot een beroepscompetentieprofiel voor de Seksverzorgende [Outline of a professional competency profile for the Sex Care Worker]. FleksZorg, the Netherlands (2021).
38. International Professional Surrogates Association.: (2022). https://www.surrogatetherapy.org/. Accessed 30
39. International Professional Surrogates Association.: https://www.surrogatetherapy.org/about-ipsa-training/. Accessed 30 April 2022
40. Limoncin, E., Galli, D., Ciocca, G., Gravina, G.L., Carosa, E., Mollaioli, D., Lenzi, A., Jannini, E.A.: The psychosexual profile of sexual assistants: an internet-based explorative study. PLoS. One. 9(6), e98413 (2014). https://doi.org/10.1371/journal.pone.0098413
41. Fabuch Social Cinema.: Impactcampagne. https://fabuch.nl/impactcampagne/. Accessed 2 April 2022
42. World Medical Association.: World Medical Association Declaration of Helsinki: ethical principles for medical research involving human subjects. JAMA. 310(20), 2191–2194 (2013). https://doi.org/10.1001/jama.2013.281053
43. Kendall, M., Booth, S., Fronek, P., Miller, D., Geraghty, T.: The development of a scale to assess the training needs of professionals in providing sexuality rehabilitation following spinal cord injury. Sex. Disabil. 21(1), 49–64 (2003). https://doi.org/10.1023/A:1023510925729
44. Post, M.W., Gianotten, W.L., Heijnen, L., Lambers, E.J., Willems, M.: Sexological competence of different rehabilitation disciplines and effects of a discipline-specific sexological training. Sex. Disabil. 26(1), 3–14 (2008). https://doi.org/10.1007/s11195-007-9068-2
45. Garofalo Geymonat, G., Macioti, P.G.: Ambivalent professionalisation and autonomy in workers' collective projects: The cases of sex worker peer educators in Germany and sexual assistants in Switzerland. Sociol. Res. Online. 21(4), 201–214 (2016). https://doi.org/10.5153/sro.4146

46. Verstraeten, M.: Maak van sekszorg een afstudeerrichting. [Make sex care a graduate program]. Bijzijn, 24–25 (2011). (2011). -2 https://doi.org/10.1007/s12415-011-0065-5
47. van Doorn, P., Kruijver, E., Hilberink, S.R.: Sekszorg als therapeutische interventie bij seksueel grensoverschrijdend gedrag door man met verstandelijke beperking. Een voorbeeld van good practice met de seksuoloog als regisserend behandelaar. [Sex care as a therapeutic intervention for sexually transgressive behavior by men with intellectual disabilities. An example of good practice with the sex therapist as directing practitioner]. Tijdschr. Seksuol. 43(2), 99–103 (2019).
48. van der Meulen-Schouten, A., van Ninhuijs, R.: De inzet van sociaal erotische zorgverlening voor mensen met een verstandelijke beperking. [The use of social erotic care services for people with intellectual disabilities]. LVB Onderzoek & Praktijk. 17(1), 17–26 (2019).

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.