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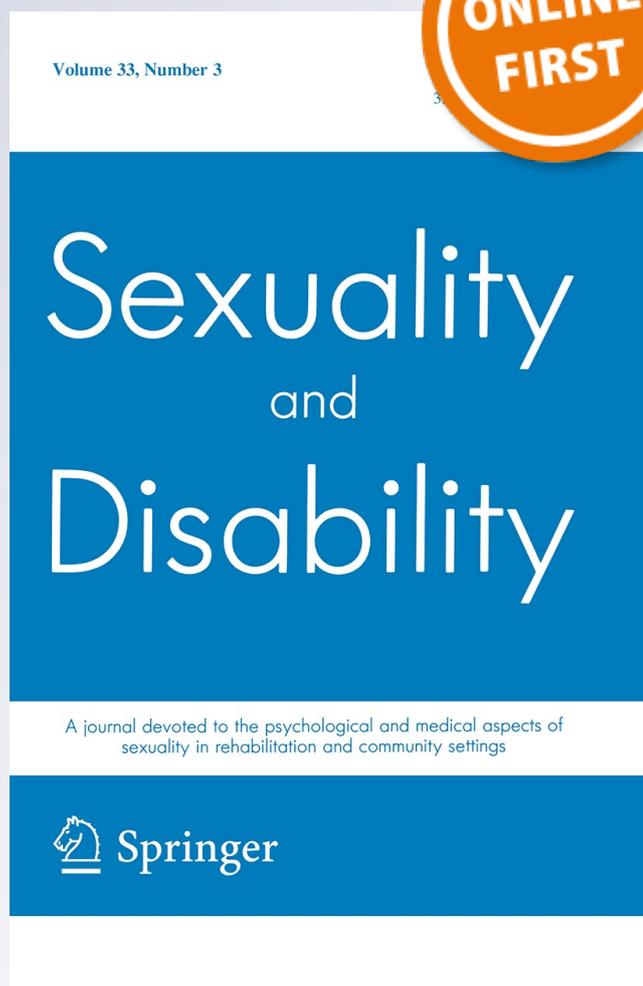
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Reproductive and Sexual Healthcare Needs Among Adults with Disabilities as Perceived by Social Workers

Kristen F. Linton¹ · Heidi A. Rueda² · Lela Rankin Williams³ · Alex Sandoval⁴ · Sharon Bolin²

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Abstract People with disabilities often experience unique gynecological and reproductive healthcare needs, which may be exacerbated by their experience of sexual victimization. Previous research on adolescents with disabilities found that social workers held beneficial roles in supporting their clients to make empowered decisions concerning sexual healthcare, pregnancy, and parenting. This study aimed to assess the reproductive and sexual health needs of adults with various disabilities from the perspectives of their social workers. Eleven social workers working primarily with adults with various disabilities were interviewed using a phenomenological study design to offer their perspectives of the sexual and reproductive health needs of their clients. Interviews were transcribed and analyzed; themes and subthemes were identified. According to social workers, (1) adults with disabilities experienced distinctive reproductive healthcare interactions and challenges, including specific needs that were uniquely related to risks for sexual victimization and (2) social workers performed several roles in supporting sexual and reproductive healthcare of these clients, including education and brokering. Social workers demonstrated the need to support clients within a biopsychosocial framework since their biological, psychological, and social needs intersected to either restrain or empower their reproductive health. Social workers played key roles in supporting their clients in reproductive and sexual health decision-making, yet appeared to struggle to address ethical dilemmas, especially those related to ensuring their clients' well-being and self-determination. Secondly, the results of this study made a connection between challenges in adults with disabilities' receipt of health wellness exams and histories of sexual victimization.

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Introduction

Approximately 56 million people in the US have disabilities and about half of those are women with reproductive healthcare needs [1]. Additionally, women with disabilities are just as likely as others to desire pregnancy and parenting [2]. Analyses from the National Longitudinal Survey of Youth (1997–2007) found that adolescents and young adults, especially females, with intellectual, physical, emotional, mental, and multiple disabilities were significantly more likely than those without disabilities to become parents by age 20 [3]. However, people with disabilities are less likely to receive information on reproductive and sexual health from physicians [4], and more likely to be prescribed contraception and experience complications in pregnancy and parenting [5, 6]. Receipt of healthcare may also be complicated by their experience of sexual victimization [7, 8].

Background

People with disabilities may experience early or delayed puberty, difficulty managing menses, and physical differences due to their disability, which can affect their sexual development [9, 10]. Healthcare professionals often stigmatize people with disabilities as “asexual” or deem their sexual behavior as less acceptable, unsafe, or inappropriate [11]. Their legitimate right to both be free from exploitation, and to marry, have children, and retain fertility is often compromised [12, 13]. Thus, much of the reproductive and sexual healthcare received by people with disabilities is focused on preventing pregnancy [4].

General practitioners often fail to share sexual health information with people with disabilities due to reported concerns over their patients’ abilities to consent to sex [4, 14]. Physicians’ concerns regarding consensual sex are understood within research finding that people with disabilities are more likely to experience sexual victimization. Martin et al. [8] study of over 5000 women noted that women with disabilities had almost five times the odds of experiencing sexual assault as compared to women without disabilities. Patients’ experience of sexual victimization could complicate their receipt of reproductive and sexual healthcare due to the potential for re-traumatization [7]. However, this could also provide the rationale for more reproductive and sexual health information and therapeutic support for patients with disabilities. One study found that only 30 % of women with disabilities reported receiving information about sexual matters [15].

Physicians commonly focus on prescribing contraception or other methods of pregnancy prevention for their patients [6]. A survey of 162 general practitioners reported that the Pill (39.7 %) and Depo-Provera contraceptive injection (34.2 %) were the most commonly prescribed methods of contraception for their female patients with disabilities [4]. Among a sample of 23 women with learning disabilities who had experienced pregnancies, all were prescribed contraception (11 Depo-Provera, 7 Pill, 3 IUD, 1 implant, and 1 sterilized), but all reported that they had not received any information or education on contraception prior to getting pregnant [4]. Most of the women reported that someone else made the decision for them to start taking contraceptives, such as their parents or support staff. When asked

why they might stop using contraceptives, all participants except one did not know why. The women in the study feared losing services or family approval if they got pregnant again [4].

While it is seen by some as a violation of an essential human right, a more extreme form of preventing pregnancy, sterilization or tubal ligation, continues to be used in healthcare for people with disabilities, particularly for those with intellectual disabilities. In one recent study, 41 % of physicians believed that sterilization is a desirable practice for women with intellectual disabilities, and 23 % said it was desirable for men with intellectual disabilities [16, 17]. Another study of women with intellectual disabilities found that sterilization was chosen as an option by their spouses or family members and none of the women took part in the decision making process. Family members reported being influenced by health professionals in making their decision [16].

Few studies have been conducted to understand the experiences of pregnant and parenting women with disabilities. Two studies of pregnant women with disabilities found that they were more likely to receive adequate prenatal care than those without disabilities; however, they experienced more complications during and after birth [5, 18]. Women with disabilities were more likely to have had emergency room visits, hospital admissions during pregnancy, cesarean deliveries, and readmissions within 3 months of delivery [18]. Women with physical disabilities had less choice during birth, those with mental health disabilities needed more communication and support, and those with learning and multiple disabilities were less likely to report positive experiences [5]. Women with disabilities who give birth may be more likely to be separated from their children after birth than others. In a study of 13 women with learning disabilities who experienced pregnancies, nine pregnancies resulted in live births, two were stillbirths, and two were aborted. Of the nine that gave birth, seven infants were taken to local authorities and two remained with their mothers [6]. However, a study of 30 people with disabilities found that they successfully parented their children with support, which included providing parenting skills and help in accessing resources [19].

People with disabilities often experience unique gynecological and reproductive healthcare needs, which may be exacerbated by their experience of sexual victimization [3, 8, 9]. Others often make assumptions about their inability to make cognitively sound decisions; thus, individuals with disabilities are often left out of decision-making regarding their own reproductive and sexual health [6, 16]. Social workers are trained to utilize ecological systems, strengths, and justice-oriented perspectives in assessing and understanding the needs of diverse client groups. Previous research on adolescents with disabilities found that social workers held beneficial roles in supporting their clients to make empowered decisions concerning sexual healthcare, pregnancy, and parenting by promoting their self-determination, the clients' ability to be free to make their own decisions [20]. This study aimed to assess the reproductive and sexual health needs of adults with various disabilities from the perspectives of their social workers.

Methods

Data and Samples

Purposive sampling techniques were used to recruit social workers and other related professionals with experience serving adults with various disabilities. In order to

participate, interviewees had to meet the following criteria: (a) their primary caseload consisted of adults with disabilities, and (b) they had a bachelor's or master's degree in social work or a related field. Participants were informed that we broadly defined disabilities as intellectual, developmental, physical, emotional, or mental impairments. Participants were also asked to discuss how they personally define disability, as well as define disability in the context of where they work.

Phenomenological methodology seeks to prioritize the voices of those that have experience concerning the subject matter, and in doing so, to collect data until no new information is emerging. Padgett [21] recommends 8–10 interviews, while others have found that major themes may present after six interviews but that 12 is more typical of thematic saturation [21, 22]. Although a small sample size limits generalizability, it allows for in-depth exploration in interviews and is appropriate for under-researched areas of inquiry [21]. We aimed to interview a minimum of ten eligible participants. Following approval from the governing institutional review board, potential participants ($n = 32$) were recruited from a large metropolitan area of the southwestern US. Participants were located through a volunteer sheet at a free training for continuing education credits held by the first author where they signed their name, phone number, and e-mail address. An e-mail outlining relevant study details was then sent to each potential participant. Respondent participants ($n = 7$) were scheduled for an interview with either the first or fourth author. Four more participants were recruited via word of mouth. While most participants did not respond to the email invitation to participate in the study, three expressed discomfort with the study topic, including one that said it was not ethical to discuss her clients' sexual health. Additionally, three who ultimately participated expressed that they were not sure if they would be able to contribute much information about sexual health among their clients, but when they were interviewed, each provided rich dialogue on the subject reflecting that social workers may not recognize their own experience supporting their clients on this topic.

Interviews ($N = 11$) primarily took place at the agency where the participant was currently employed, and two interviews took place in a private corner of a coffee shop. At the time of the interview, participants were provided with a detailed explanation of the study's purpose, the potential benefits and costs to their participation, and a guarantee of confidentiality. All decided to continue with the interview, and written consent was obtained from each participant. All interviews but one were digitally recorded (participant 11 did not consent to be digitally recorded), transcribed verbatim, and checked for reliability by a trained research assistant and trained research volunteer. The authors consulted the data for themes and agreed that saturation was met after interviews were conducted with eleven participants. Bracketing and triangulation were used to enhance the rigor and trustworthiness of the study. The confirmability of the study was strengthened with the use of multiple perspectives to analyze interviews; the researchers on this study specialize in different areas (that is, disability and adult reproductive health and sexuality), and an independent research assistant was used for coding, making thematic agreement particularly credible [21].

The resulting sample consisted of participants ($N = 11$) ranging from 1.5 to 32 years of experience working in the social work or social work related field ($M = 13.49$, $SD = 10.17$) and 1.5–32 years working with adults with disabilities ($M = 12.10$, $SD = 11.08$). The majority of the sample identified as Caucasian ($n = 9$, two male). We also interviewed two Mexican–American women. The age of the sample ranged from 33 to 66 years ($M = 50.09$ years, $SD = 11.54$). Interviewees were asked to describe their unique experiences, the services they provided, the needs of adults with disabilities, and

their professional needs in supporting them towards reproductive health. They reported that they served adults with various disabilities including intellectual disability, Autism Spectrum Disorders, Down's syndrome, Cerebral Palsy, seizure disorder, stroke, head injury, and terminal illnesses.

Analytic Strategy

We utilized inductive content analysis to analyze for emergent conceptual meanings, and participant dialogue is prioritized in communicating the results. This is evidenced by the use of direct quotations from participants. Audio-taped recordings were transcribed verbatim and read multiple times by the authors to develop a codebook. Codes were identified as recurrent and prominent themes across study subjects. Themes and subthemes were identified and given priority not only by their repetition, but by the extensiveness, the use of stories, emotionality, and specificity (i.e., personal nature) of examples offered [23]. The codebook was developed by the first and fourth authors. A kappa of .80 was reached in assessing inter-rater reliability of coding conducted by the fourth author and an independent research assistant using the final codebook. Descriptions of reproductive and sexual health needs were identified as a prominent theme and form the basis of the present analysis.

Results

According to social workers, reproductive health services for adults with disabilities are multifaceted. Two main interrelated themes emerged from interviews, including that adults with disabilities (1) experienced distinctive reproductive healthcare interactions and challenges, including specific needs that were uniquely related to risks for sexual victimization and (2) that social workers performed several roles in supporting sexual and reproductive health of these clients, which included education and brokering. However, social workers noted needs and challenges in performing these roles, which included gaps in sexual education and struggles with ethical dilemmas regarding autonomy and client well-being. Social workers demonstrated the need to support clients within a biopsychosocial framework since their biological, psychological, and social needs intersected to either restrain or empower their reproductive health [24]. Acknowledgment of the client's cognitive, physical, and reproductive abilities as well as their family systems and histories of sexual victimization were necessary in supporting reproductive healthcare decision-making.

Sexual and Reproductive Healthcare Risks and Needs

Social workers described unique sexual and healthcare experiences and needs in their work with adults with disabilities. They reported that their clients often experienced sexually transmitted infections (STIs), pregnancy, and parenting. However, participants expressed that their clients generally did not protect themselves from STIs or unplanned pregnancy, and at times faced challenges with regard to parenting.

"HIV positive and dating several women." HIV and genital warts were the most commonly reported STIs experienced among the adults with disabilities served by the social workers. Participants reported adults with disabilities they served did not generally

use condoms nor ask their partners about their STI status. Social workers expressed that this was due to feeling unsafe, having inadequate knowledge, or being unconcerned about STIs. As a result of rushing into intimate relationships and not being familiar enough with their sexual partners, clients often “don’t feel safe with them [their partners] enough to even ask them if they have a STI.” This is also coupled with social workers’ observations that many of their clients did not receive sexual education when they were younger. STIs often placed social workers in ethical dilemmas. One social worker described a scenario in which a client was HIV positive and “dating several of the women that were in our [disability services] program. And we couldn’t tell them he was HIV positive, because that’s protected information. So... we wound up...tell[ing] them they could not date him.”

“I’ve seen my fair share of unwanted pregnancies.” Social workers expressed that pregnancies, especially those that were unplanned, were common among people with disabilities. While social workers recognized that some of their clients desired pregnancy and children, even those that did not desire pregnancy did nothing to prevent pregnancies, such as using condoms or birth control. Similar to the reasons why they did not act to prevent STIs, many did not prevent pregnancies due to lack of education, feelings of insecurity, or fear of reprisal. One social worker illustrated:

It could be anything from, let’s say there’s an adult woman with [an] intellectual disability that lives in an apartment and there’s some person in their apartment that recognizes that she’s “a vulnerable adult”. And will go over and have frequent sex with her, just for the sake of having sex with her- she ends up pregnant. Maybe she doesn’t tell anybody for a while, because she’s afraid that this might mean I have to live in a group home or that I’ve done something wrong and she’ll be judged. So I’ve seen terminations of pregnancies in regards to that.

“We have more and more individuals that we serve that have children.” Due to changes in philosophies and policies in more recent years, adults with disabilities are more likely to be supported by social workers to raise their own children. One social worker reflected on this change: “About 20 to 25 years ago... we terminated their rights. So those children were placed in foster care or adoption...because they weren’t able to manage children.” While social workers expressed that it was challenging for parents with disabilities to raise children, many felt that “they can be effective caregivers” with supports in housing, pediatric healthcare, finances, and grocery shopping. However, other social workers expressed that they often see clients who have multiple children and “they go into the system in which they’re in foster care, adopted out, or they go to a family member and they’re raised by a family member with a normative IQ.”

Moderating Influences on Reproductive Health

Social workers also reported that access to, and decision making regarding, reproductive and sexual healthcare for adults with disabilities were often moderated by protective family members or by previous sexual victimization experienced by the client.

Family/Guardian Influences

“Most families are really protective.” Social workers reported their clients experienced challenges in reproductive health due to protective family members/guardians who (1) limited their child’s autonomy in accessing healthcare, (2) thought of the person as childlike or asexual, and/or (3) promoted sterilization.

Social workers expressed that more often than not the family members of adults with disabilities were protective of their sexuality and reproductive healthcare. One social worker explained that: “You get people that are overly involved to where like, I’m dating Stacy, but I’m also dating Stacy’s mom, because Stacy’s mom is her guardian.” The protectiveness of family members or guardians was often seen as a barrier in obtaining reproductive health services.

Another social worker expressed not feeling comfortable discussing preventing pregnancies with family members of their clients due to their protective nature: “Even if their child is in their forties, they still think of them as little kids, so it’s hard to bring up...like birth control and stuff like that.” The following quote also speaks to the perceived asexuality of persons with disabilities on behalf of parents and guardians:

It’s like are you going to take them to the OBGYN...and they’re like, “not my daughter.” Your daughter is 18. She’s going to have sex. You need to come to this realization. “Not my daughter. She has a disability.” Just because she has a disability doesn’t mean she doesn’t have human urges... Yeah... “My child is disabled, he doesn’t participate, he doesn’t masturbate or do any of this.”

Social workers also discussed a linkage between guardianship and tubal ligation. While one social worker believed that guardians often encouraged sterilization (“when she gets a guardian, it might be difficult to keep her from being sterilized”), another expressed that “you can’t make them have a tubal ligation even if you’re the guardian.” Their clients’ guardians were typically family members while some were appointed public guardians.

Challenges Related to Sexual Victimization

Family members’ protectiveness may stem from the high prevalence of sexual victimization, seen by social workers, among adults with disabilities. The ubiquity of sexual victimization among adults with disabilities complicated their receipt of reproductive and sexual healthcare according to social workers.

“Many do not feel comfortable getting a personal exam.” Social workers reported that the majority of their clients with disabilities had been “molested or assaulted”. One social worker reflected on a client of hers who had three children as a result of sexual assault: “A beautiful woman...she was sexually assaulted multiple times and the births were a product of that.” All social workers who discussed sexual victimization among their clients expressed that they were targeted due to their disability and lack of capacity to refuse sexual and other advances. One expressed: “Sometimes what happens with people who abuse developmentally disabled people is they find people who are nonverbal and there is no way of knowing that this person has been abused.” Peers, support staff, teachers, boyfriends/girlfriends, and spouses were reported as perpetrators. The invasiveness of health procedures, such as pap smears, presented a problem for those who had been victimized. Referring to clients choosing not to get pap smears, a social worker stated, “With that [sexual victimization] happening, many do not feel comfortable getting a personal exam.” This discomfort, however, limited clients’ access to birth control: “Many doctors won’t give you birth control unless they do an exam.”

Social Worker’s Roles

Social workers reported they were involved in encouraging adults with disabilities to receive annual wellness exams, including vaginal exams for women, as well as supporting

clients in decision-making regarding pregnancy and the prevention of STIs. Social workers focused their interventions toward education and brokering.

Social Workers as Educators

Many social workers perceived education as a measure that could be taken to prevent STIs, unwanted pregnancies, and sexual victimization.

Social workers were engaged in ensuring the well-being of their clients by encouraging annual wellness exams including pap smears for women. However, one social worker expressed challenges in getting her clients to receive pap smears, but she felt that “ultimately it is the person’s decision” whether or not they chose to receive them. Social workers educated clients on reasons to receive a pap smear, which included obtaining information and healthcare related to STIs and pregnancies. Condoms were discussed as an option to prevent STIs by social workers; however, some expressed that they did not anticipate their clients using them: “they’ve demonstrated very little care to say ‘we’re alone, we’re going to have sex...let me go grab a condom’.”

If the client did not want to get pregnant and was her own guardian, the social workers would often “encourage them to use birth control.” Birth control and tubal ligation (sterilization) were the most common forms of pregnancy prevention discussed. Social workers appeared more comfortable with birth control than tubal ligation. More than half of the social workers mentioned tubal ligations as a pregnancy prevention option but were keenly aware of the ethical implications of the procedure: “sterilization is a big slippery slope”. One participant expressed that people with disabilities should be protected from sterilization, “because for many, many years ago people were having people with developmental disabilities or mental health issues sterilized.” Another shared an example that demonstrates a recent potential use of sterilization:

I was taking a young lady to a doctor, a neurologist, because she was experiencing seizures. And she had...I’d say the mental capacity of a six year old, but she was 18 going on 19. She had a boyfriend, and the doctor thought it would be best that she be either put on medication, birth control, or to be essentially sterilized so that she didn’t get pregnant. The doctor didn’t understand that this was quite a legal process to even consider something of that nature.

Social workers mostly reported having conversations with their clients about the clients’ desire for pregnancy. Social workers were not consistent in their responses to their clients’ desire for pregnancy. While some discouraged them from having children or seemed to dodge the topic altogether by deferring discussions of pregnancy to their clients’ guardian, the majority saw it as a right. If the client desired pregnancy, social workers would discuss parenting responsibilities as a form of educating their client. Education was also mentioned as a way of ensuring that adults with disabilities were making informed decisions regarding family planning: “If they tell you they want children, we try and tell them why they shouldn’t or what are the responsibilities of having children. And why it is so overwhelming.”

Brokering

While social workers often were providing the education themselves directly with clients, brokering was also commonly reported: “Part of the philosophy was to have people use

community resources. Whether it be physicians, or Planned Parenthood, or the health department... we might have them go to [AIDS organization] and get some education.”

Social Workers' Needs and Challenges

Social workers reported some needs and challenges in performing these roles to support the sexual and reproductive health of adults with disabilities. Specifically, they noted gaps in sexual education, and they reported struggling with ethical dilemmas in providing support, particularly in the area of self-determination versus client well-being.

Needs in Sexual Education

Social workers reported a need for sexual education to begin earlier, to include strategies to improve planning and decision-making regarding contraception/family planning, and to be better targeted to reduce initial occurrences of sexual victimization. Sexual education was needed prior to adulthood according to social workers: “If they taught it while they were younger, in schools or mandated them to go to some type of treatment classes... I would imagine that maybe the population would have healthier relationships and healthier sexuality.” The education should include information on birth control, contraception, and consequences of behaviors, such as, “if they engage in that...then there’s certain things that might happen.” Educational interventions often focused on training adults with disabilities about reporting abuse, yet this social worker expressed that it did not prevent initial occurrences of victimization:

There’s been a lot of training now with giving people their rights. Also telling people that it’s not appropriate for someone to touch you, if you feel uncomfortable, you need to report it. You need to tell the social worker that is assigned to you. A policeman or whomever you trust. We do a lot of training with that, and I don’t think I actually saw a reduction in that. It’s still happening but people are reporting it, our clients are reporting it but they’re reporting everything...like smacking them, they’re reporting it all. And if you’re a client...we have to investigate everything and our policy was that if somebody filed a complaint, that person on staff was put on suspension until that investigation was done. And we actually had people who were trained by local police people on how to do an investigation and what to look at. And ultimately, if you’re state funded, and if there is enough evidence where we feel this may have happened, that person can no longer work with people with developmental disabilities.

Challenges with Ethical Dilemmas

Social workers struggled with ethical dilemmas as they supported their clients towards sexual and reproductive health. Specifically, client self-determination and well-being often conflicted. Participants expressed a desire to support their client’s decisions (“We work as a team...We did have an individual that ended up getting pregnant and...even with the service supports, she ended up losing the child to foster care.”), yet often reported encouraging certain choices (“If it’s a female, we do make sure that they get birth control or have the appropriate mechanisms to prevent pregnancies.”). Additionally, social workers described a lot of tension in agreeing with family members’ or guardians’ protective nature. This participant expressed that protective parents could get in the way of educating clients:

Just maybe if there could be a program that... gives them education. But in a safe environment away from their parents who are like, "no, no, no, you're disabled, you can't do that." Letting them realize that yes, they are adults, they can act upon, responsibly act upon their needs and wants. ...it's a whole different society and now that there's a push to integrate people with disabilities into work places and have them in competitive employment. They're going to meet people, they're going to fall in love but not know how to have a healthy relationship.

Discussion

Interviews with social workers found that they frequently addressed reproductive and sexual health needs among their adult clients with various disabilities. Social workers were primarily concerned with STIs, preventing pregnancy, and supporting their clients who had children, which is similar to the roles that a separate sampled group of social workers held in supporting adolescents with disabilities [20]. Social workers encouraged the use of condoms and birth control, yet were leery of tubal ligations even though they acknowledged the procedures as options. Social workers held a distinct role in encouraging their clients to obtain annual physical exams including pap smears, but often faced barriers to their clients receiving the exams due to protective parents or histories of sexual victimization. They felt that education was needed in order for adults with disabilities to make informed decisions regarding their reproductive and sexual health needs.

Social workers played key roles in supporting their clients in reproductive and sexual health decision-making. However, social workers appeared to struggle to address ethical dilemmas, especially those related to ensuring their clients well-being and self-determination [25]. While social workers were critical of protective family members limiting the choices of adults with disabilities, social workers often provided biased recommendations, such as encouraging birth control and informing clients that desired pregnancy only about the challenges in parenting, rather than informing their clients of benefits and challenges or all options available to them. Social workers acknowledged the strengths of their clients, but also challenges related to capacity to consent to sex or reproductive healthcare decisions. This may suggest that social workers should provide education that is informative and supports both the clients' autonomy and takes into consideration factors in the clients' biopsychosocial sphere regarding their adult clients with disabilities' reproductive and sexual healthcare decisions. Social workers may also ensure that their clients are a part of the decision-making process and aim to work with family members of their clients.

While other studies have found that there are many sexual and reproductive health needs among adults with disabilities, especially those pertaining to family planning decisions, the results of this study made a connection between challenges in adults with disabilities' receipt of pap smears and histories of sexual victimization. Invasive medical exams, such as pap smears, may be re-traumatizing for a victim of a sexual offense and adults with disabilities are more likely than the general population to experience sexual victimization [7, 8]. According to the social workers in this study, reproductive healthcare professionals should be knowledgeable and sensitive to the fact that there is a higher possibility that their patients with disabilities may have a history of sexual victimization and feel especially uncomfortable having a pap smear. Because pap smears can provide essential information about sexual health, they are especially important for those who have experienced sexual victimization. Thus, social workers should provide education to their

clients who have been victimized about what the procedure entails and benefits of it. They may also advocate for trauma-informed approaches to interventions for adults with disabilities. Primary care physicians may also be trained in trauma-informed care [26].

Lastly, social workers focused a lot on women's reproductive healthcare and roles in preventing pregnancy and parenting. While their male clients were mentioned, such as in the example of a male client with HIV dating female clients and possible exposing them to HIV, they were typically referred to as sexual perpetrators. Their roles in consensual sexual relationships that contributed to pregnancy and fatherhood were not discussed by social workers. Other research among physicians has acknowledged their opinions of men with disabilities' pregnancy prevention [16, 17]. Future research should explore the perspectives of social workers on the reproductive healthcare needs of adult men with various disabilities.

Limitations

Although this study brings new information regarding the reproductive and sexual health of adults with disabilities and roles of social workers in supporting their health, it has several limitations. The data is from the perspective of social workers. The data does not provide information about how adults with disabilities perceive their own needs and experience healthcare. The sample of social workers is small, yet is reflective of methods used in qualitative research, which often must sacrifice breadth for depth [21]. Lastly, this study explored the needs of adults with various disabilities, thus it does not provide specific experiences of those with certain disabilities. The authors chose to broadly define disability due to the exploratory nature of this study and because social workers typically serve people with various disabilities rather than only one specific type [27].

Conclusions

This study suggests that social workers need to provide ethical services that ensure the rights of adults with disabilities to participate in reproductive healthcare decision-making, have children, and have access to resources to ensure their well-being. Healthcare providers should be aware of and sensitive to possible sexual victimization among adults with disabilities especially relating to their receipt of sexual health exams, such as pap smears. Social workers may advocate for earlier provision of sexual health education that would include decision-making support regarding parenting, and a focus on preventing first victimization in addition to reporting abuse. Furthermore, according to this study, social workers are uniquely poised to inform the ethical debate about sexual and reproductive healthcare of adults with disabilities, taking into account the unique biopsychosocial needs of the population while supporting both autonomy and right to intimacy and client well-being.

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