

Experiences with Pregnancy of Adolescents with Disabilities from the Perspectives of the School Social Workers Who Serve Them

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Adolescents with disabilities are more likely than adolescents without disabilities to become pregnant, although very little is known about the lived contexts of their sexual and pregnancy experiences. Such youths are often deprived of sexual health information across a range of potential sources, although school social workers are in a unique position to provide them services. Thirteen school social workers working primarily with adolescents with disabilities were interviewed using a phenomenological study design to offer their perspectives concerning the sexual and pregnancy experiences of such youths. Inductive content analysis revealed that school social workers provided services for pregnant and parenting adolescents with a range of disabilities in areas that included making decisions about sex, deciphering whether they were pregnant, and making decisions once they were pregnant. These experiences were complicated by cognitive impairments; emotional struggles; desires to fit in with peers; histories of sexual abuse; and issues with communication, self-esteem, and impulsivity. School social workers play an integral role in preventing pregnancy and supporting adolescents with disabilities who are pregnant. Recommendations pertaining to the provision of sexual health services for adolescents with disabilities are provided.

KEY WORDS: *adolescents; disabilities; pregnancy; sexuality; teenagers*

“They don’t have anyone else they are talking to. . . . There was no support other than talking to me.”

—Tamara, school social worker

Every day in the United States, approximately 1,100 adolescent girls ages 15 to 19 years become mothers ([Centers for Disease Control and Prevention, 2011](#)), and a nationally representative sample indicated that adolescents with disabilities are approximately 15 percent more likely to experience pregnancy and to parent than other teens ([Shandra, 2011](#)). Sexual experimentation during the adolescent years is a normal developmental milestone in the United States ([Martinez, Copen, & Abma, 2011](#)); however, health care professionals, schools, parents, and peers often stigmatize adolescents with disabilities, considering them “asexual” or deeming their sexual behavior less acceptable, unsafe, or inappropriate (for a review, see [Shandra & Chowdhury, 2012](#)). As a result, adolescents with disabilities are often deprived of sexual health information across a range of potential

sources, despite their increased likelihood to forgo contraception ([Cheng & Udry, 2005](#)) and to be victimized by sexual assault ([Alriksson-Schmidt, Armour, & Thibadeau, 2010](#)). School social workers are called on to provide services to adolescents with various disabilities, often in an undifferentiated manner and as defined by the [Individuals with Disabilities Education Act \(IDEA, 2004\)](#) (P.L. 108–146), to youths with mental retardation, hearing, visual, speech, or language impairments, serious emotional disturbance, autism, traumatic brain injury, specific learning disabilities, or other health impairments. Although we know very little about social workers’ perceptions concerning the provision of such services, we do know that by providing interventions and resources for adolescents with a range of disabilities, social workers are likely to hold a pivotal role in the sexual health and pregnancy needs of this population. Given their unique position to inform the scarce literature, this study used a phenomenological study design to afford voice to school social workers’ descriptions of sexual experiences specific to pregnancy and parenting of adolescents with disabilities. We conclude by

elucidating educational system failures and with recommendations for reaching adolescents early with appropriate sexual health information.

PREGNANCY AMONG ADOLESCENTS WITH DISABILITIES

Data from the National Longitudinal Survey of Youth (1997–2007) found that adolescents with a range of disabilities were more likely to expect and to become parents by age 20 than those without disabilities (Shandra, 2011). This finding was more pronounced for females and was statistically significant across a range of disability types (that is, intellectual, physical, emotional, mental, and/or multiple disabilities). Adolescents with a range of both severe and mild disabilities are less likely to finish high school. In addition, females in particular are more likely to see themselves as unable to pursue career-related ambitions and rather to aspire to and follow through with family-oriented goals (Shandra, 2011; Shandra & Chowdhury, 2012). Other studies have also pointed to disability as a risk factor for experiencing pregnancy, documenting lower cognitive scores (Shearer et al., 2002) and social-emotional difficulties among adolescent mothers (Yampolskaya, Brown, & Greenbaum, 2002). Aside from evidenced risk of becoming pregnant, these findings highlight difficulties the adolescent may face in choosing how to handle the pregnancy (for example, decisions whether to abort, to keep, or to adopt) and concerning parenting itself. Decisions whether and how to parent are wrought with ethical considerations, particularly as parents often make many decisions for adolescents with disabilities and take care of them to a greater degree (Blum, Resnick, Nelson, & St. Germaine, 1991). Moreover, adolescents with disabilities often experience gynecological issues and take medications (Greydanus & Omar, 2008), further explicating the complexity of social workers' roles in working with such youths as they engage in unprotected sexual intercourse and become pregnant.

CONTEXTS OF INTERCOURSE

Adolescents with mild disabilities are more likely to either experiment in uncommitted sexual contexts (that is, with a stranger) or to engage in sexual relationships only in highly committed contexts (for example, marriage; Shandra & Chowdhury, 2012). To the contrary, a majority of typically developing adolescents' first sexual experiences are

within dating partnerships (Martinez et al., 2011). This bifurcated relationship found among adolescents with disabilities may stem from internalization of negative sexual stereotypes, which in turn contribute to poor self-esteem, less sexual efficacy, and a tendency to view themselves as less sexually desirable (Wiegerink, Roebroek, Donkervoort, Stam, & Cohen-Kettenis, 2006). Insecurities may also stem from a number of issues related to their disability, including pubertal issues (for example, either delayed or early pubertal development among adolescents depending on disability type and medication use; Greydanus & Omar, 2008), gynecological dissimilarities (for example, difficulty managing menses and increased nausea and vomiting during menses for certain disabilities; Grover, 2011), and physical impairments (Shandra & Chowdhury, 2012). Such difficulties may lead teens with disabilities to feel pressure to demonstrate their sexuality by engaging in sexual activity (Greydanus & Omar, 2008) or to experiment within uncommitted contexts so as not to have to disclose a less overtly noticeable disability (Shandra & Chowdhury, 2012); it may also be that measures of uncommitted contexts capture a greater likelihood for adolescents with disabilities to experience sexual assault. Regarding the latter, studies have found that adolescents with a range of disabilities are significantly more likely to experience sexual victimization (Alriksson-Schmidt et al., 2010). Alternatively, some adolescents with disabilities may entrust their sexual selves to highly committed partners only (Shandra & Chowdhury, 2012). The contexts of sexual intercourse among adolescents with disabilities hold important practice implications for reaching them with effective sexual health services, although qualitative studies are lacking.

SOURCES OF SUPPORT

Sexual health information that is appropriate to adolescents' lived socioemotional contexts is lacking, as 38 states have abstinence-only policies (Stanger-Hall & Hall, 2011) and adolescents with disabilities are often excluded from sexual health curricula in schools or do not understand it (Swango-Wilson, 2011). Adolescents with disabilities are also less likely than adolescents without disabilities to learn about reproductive processes, sexual activity, and potential sexual outcomes (pregnancy, sexually transmitted infections) from their peers, parents, or doctors (Blum et al.,

1991). Regarding peers, they tend to have smaller social networks and are less likely to date, to experiment sexually in social contexts, or to talk with friends about sex (Blum et al., 1991; Shandra & Chowdhury, 2012; Wiegerink et al., 2006). Mothers of adolescents with disabilities often refrain from talking with their teens about sex and are more cautious about the use of contraceptives despite having concerns about their adolescents' sexual vulnerability (Pownhall, Jahoda & Hastings, 2012). Finally, doctors often fail to share information with parents and adolescents about how physical impairments may affect sexual intimacy (Blum et al., 1991). As a result, adolescents with a range of disabilities may hold a poor understanding of their own sexuality and their bodies, and they may believe false information. Internalization of sexual stigma may also promote sexual risk taking. Emotional considerations central to sexual intercourse are left unaddressed as attention is afforded most heavily to risk avoidance (Shandra & Chowdhury, 2012).

THE PRESENT STUDY

School social workers provide critical sexual health education and support to many adolescents with disabilities who are not otherwise offered any (Adams Rueda & Linton, 2014). Given that social work services are provided to adolescents with various disabilities, we interviewed social workers with the aim of better understanding adolescents with a broad array of disabilities' sexual experiences and needs. Semistructured individual interviews were conducted to gain high-quality data, to provide the opportunity to probe individual responses to questions, to allow sufficient time to elaborate on experiences, and to offer a high degree of confidentiality (Padgett, 2008). Using a phenomenological study design allowed for the exploration of experiences from the perspectives of those interviewed and for themes to arise from the data rather than from preexisting a priori hypotheses (Padgett, 2008). The questioning route included numerous inquiries and probes pertaining to the sexual and dating experiences and needs of adolescents with disabilities as well as social workers' roles in working with such youths. Despite not having asked directly about pregnancy and decisions to parent, this theme emerged as prominent and is thus the focus of the present analysis.

METHOD

Sampling and Procedure

Purposive sampling was used to recruit social workers with experience supporting adolescents with disabilities (Padgett, 2008). Participants were required to meet the following criteria to participate: (a) Their primary caseload consisted of high school students with disabilities, and (b) they had a master's in social work degree and at least two years of practice experience in a school setting. Participants were informed that we broadly defined disabilities as intellectual, developmental, physical, emotional, or mental impairments, although they were also asked to describe how they defined disability. Although every effort was made to avoid stigmatizing language in this article, we keep with a phenomenological study design in reflecting the vernacular used by the social workers interviewed. Most social workers described that they worked with adolescents with emotional disabilities (the "E.D. kids") and/or intellectual disabilities as evidenced by individualized education plans ("IEPs"; often referenced as the "sped" kids for their participation in special education). Often social workers worked with both types, which were often co-occurring, and at times discussed other disability types (for example, physical disabilities).

Phenomenological methodology aims to collect data until saturation is met, when information is redundant and not new. Padgett (2008) recommends at least 10 interviews, and we aimed to interview at least 12 participants. With approval from the institutional review board, potential participants ($N = 18$) were recruited from a metropolitan area of the southwestern United States. Participants were located using school Web sites and were sent an e-mail outlining the study details. Participants who responded were sent a consent form and scheduled for an interview with the first or second author ($n = 8$). Five more social workers were recruited via word of mouth. Interviews ($N = 13$) primarily took place at schools, and one interview took place in a private corner of a coffee shop. Social workers were provided with a study description, including our intent to understand the sexual and dating experiences of adolescents with disabilities as well as social workers' needs in working with these adolescents, the costs and benefits of participation, and assurance of confidentiality. Written consent was obtained from each

participant. After digital recordings of the interviews were transcribed verbatim and checked for reliability by a team of trained researchers, the authors consulted the data for themes and agreed that saturation was met after interviews were conducted with 13 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 adolescent dating and sexuality), making theme agreement particularly credible (Padgett, 2008).

The sample consisted of school social workers ranging from four to 33 years of experience working in schools ($M = 14.8$, $SD = 8.8$) and two to 27 years working with adolescents with disabilities ($M = 8.8$, $SD = 6.6$). The majority of the sample identified as Caucasian ($n = 9$, one male). We also interviewed one Chinese American woman, two Italian American men, and one multiracial woman. Their ages ranged from 30 to 54. Interviews lasted approximately one hour. Interviewees were told to think of adolescents with disabilities or to compare their experiences working with adolescents with and without disabilities during the interview. One participant, "Rose," primarily supported pregnant and parenting adolescents in her work.

Analysis

We used inductive content analysis to raise codes to recurrent and prominent themes across participants. Dialogue was given weight based not only on how often an experience was discussed but also qualitatively via extensiveness, the use of stories, and emotionally salient examples. Using NVivo software (QSR International Pty Ltd., 2008), we created an initial set of codes from a full interview transcript. The second author continued to code the remaining interviews in this manner and added codes where applicable until themes began to emerge. One or more codes could have been assigned for every segment of text, and all text was analyzed. Categories identified as "tree nodes" subsumed multiple codes. Descriptions of pregnancy experiences of adolescents with disabilities (that is, including the contexts in which they became pregnant, decisions concerning their pregnancy, and whether to parent) were identified as a prominent (that is, a

"tree node") theme. The codebook concerning this theme was revised until agreement was reached and subthemes were also apparent to both authors. A kappa of .84 was reached in assessing interrater reliability of coding conducted by the second author and an independent research assistant in using the final codebook.

RESULTS

Social workers provided rich contextual descriptions of cognitive, emotional, and behavioral intrapersonal characteristics pertaining to varying disabilities and that intersected with sexual behavior leading to pregnancy. Distinct risk factors were broadly ascribed to certain disability types; specifically, social workers repeated the following characteristics typical of high school-age students that they described as emotionally disabled: lacking in judgment, impulsive, in the moment, unable to discern consequences, lacking interpersonal/communication skills, and at times dependent on the relationship to meet emotional needs. Intellectual impairments of varying degrees of severity were further associated with barriers to understanding basic sexual anatomy and increasing pregnancy risk. Despite these generalizations made, social workers' examples highlighted the complexity of sexual experiences in working with caseloads consisting of a range of often co-occurring and/or undifferentiated disorders. Social workers' roles in working with adolescents with disabilities and adolescents' experiences with pregnancy and decisions to parent were captured across each of three temporal domains: "I'm having sex"; "I might be pregnant"; and "I'm pregnant." Each of these primary themes is described adhering closely to social workers' dialogue and using example quotations in line with a phenomenological study design. Subthemes emerged within each temporal stage and are further exemplified by social workers' quotations. Information pertaining to disability type and severity is included when social workers referred to either. Pseudonyms are used to protect participants' identity.

"I'm Having Sex"

The majority of social workers' dialogue concerning the experiences with pregnancy of adolescents with disabilities and their decisions to parent was rooted in such individuals' heightened vulnerability for unprotected intercourse. This first temporal

theme consisted of a great deal of dialogue, rich with many personal examples from social workers' practice.

"They have hormones just like everyone else."

Vulnerability was situated within developmental contexts, as the sexual bodies of adolescents with disabilities underwent similar hormonal (pubertal) changes as others of the same age, leading them to sexually experiment but without always grasping what was happening or fully weighing the potential consequences. Coupled with a desire to be normal and socially accepted, sexual experimentation was contextualized within additive developmental risk factors:

Sometimes educators think that they don't have the cognition to really understand about sex or to want it or to pursue it, but they have hormones just like everyone else, and they have desire . . . so they are sexually active without really realizing or having a complete understanding of what that really means. You know, especially if they're easily led by social behavior, how simple would it be to say, "Everyone does this, it's what you do when you're friends" . . . "Oh let me touch you here."

"They are just jumping into sexual relationships for the wrong reasons." Many social workers felt that adolescents were at a particularly high risk of sexual intercourse as a means through which to fulfill self-esteem needs. However, this was discussed only of girls, as typical of many adolescent girls but as particularly pronounced for girls with disabilities. Thus, emotional needs often fused with sexual prompting to override judgment: "They're more vulnerable to coercion, and manipulation, and believing, 'He loves me, he's going to stay with me, it's okay to do this'" (Rose). Despite girls' vulnerability, sexual gatekeeping was seen as their responsibility. For example, Sam stated that "If I see a girl with a hicky on her neck, I'll talk to her about interactions between boys and girls and teaching girls how to say 'no' to a guy . . . about how to be assertive. Adolescent guys act stupid." To the contrary, Kathy felt that assertiveness training was futile for adolescents with disabilities, who were often severely lacking in self-respect: "It's so primitive, it's so sexual what these girls will do. You can't even get to 'You

need to respect yourself.' That is not in their frame of reference."

A lack of self-esteem was particularly risky when an adolescent used drugs and alcohol to cope with the disability and when paired with intellectual impairment: "And sometimes the use of drugs and alcohol to self-medicate. For the disability. And so then they find themselves in sexual situations. And then they turn into typical [girls] where maybe they don't have the self-esteem to say 'no.' They don't have the decision-making process. They don't" (Rose). Many others similarly described adolescents with disabilities, and particularly girls, as inclined toward promiscuity (for example, "She probably went through almost all the boys here" [Kathy]). The reasons they gave differed and ranged from a lack of understanding (for example, "Their idea is they are being monogamous because it's just with one person. They don't understand the whole concept" [Tony]) to a contemporary adolescent culture that popularized sleeping around: "It's somebody that they hooked up with, or some guy that they went to a party with or some guy that they met and now they're doing it. I guess I'm old school" (Tamara). This peer norm fostered a sexual environment ripe for adolescents with disabilities that desired connection and were vulnerable to manipulation; Rose further tied promiscuity with unresolved emotional harm that sometimes stemmed from prior molestation: "The few that I can think of that were raped . . . promiscuous, highly sexually active . . . Let's heal that, and deal with that, and help them understand their self-worth and respect and grief process in dealing with it."

"A lot of unprotected sex. So in relationships and in casual hookups." In addition to heightened promiscuity, social workers described how adolescents with disabilities often forwent contraception (for example, "I think they're just playing Russian roulette pretty frequently" [Natalie]). As Sam described, "I sense that from my experience with these students, like the one I spoke to this morning who just found out that he's going to be a father . . . they don't seem to use contraceptives. So we seem to have a large rate of STD and a significantly large rate of teen pregnancy." Part of this stemmed from perceived peer norms (for example, "It's sad that it's not a positive thing to use contraception. It's looked down upon" [Tamara]), and many social workers again reiterated that it was the girl's

responsibility to assert herself and to communicate the need to use contraceptives (“You know, some girls are responsible but no, not in all cases” [Ellen]). Part of this gender bias arose from girls’ tendency to approach social workers with issues concerning their sexual lives: “Well I don’t talk to too many males. I have a couple of male students that have girlfriends that are pregnant. Umm, and I don’t know that they’re taking ownership of using birth control as much as the girls are” (Allison). Social workers desired to implement communication and assertiveness skills with girls, but this was complicated by deficits resulting from the disability. Tamara stated that

The girls should be pushing it . . . so the guy’s not going to say anything if he can get away with it. I think it comes down to communication and our students struggle with that. Vocabulary-wise and initiative-wise. They will seriously be in a relationship and not talk to one another. I mean, really, yeah.

Furthermore, girls with disabilities sometimes faced added restrictions at home and were fearful that if they came forward with the need to purchase birth control, they would face even more restrictions (“and she said her parents were strict already, she felt she didn’t have a lot of freedom . . . she was afraid she’d be restricted even more. So she was not willing to take that risk” [Rose]).

Sometimes the decision not to use protection was tied to being in the present moment: “I’ve had a couple students come to me and say, ‘I’ve had sex and didn’t use anything.’ Because of their cognitive base, they are not thinking of tomorrow. They’re thinking of the moment and their physical sensation of it” (Sam). Rose specifically mentioned attention deficit/hyperactivity disorder (ADHD) in her discussion of adolescents’ tendency to become caught up in intercourse: “Well, the ADHD is just behavior . . . Um, just not thinking of the consequences and just really being in the moment. And maybe not having that filter to stop and say, ‘Okay, this isn’t safe.’” In some cases, social workers felt that adolescents with disabilities simply did not grasp that unprotected sexual intercourse could result in pregnancy (“They definitely don’t recognize the consequences” [Ellen]), which was not often apparent by the mild nature of their disability:

She had been sexually active for a while at the time she became pregnant. She was high functioning also. You would have to talk to her for a while to realize that she was MMR [mild mental retardation]. . . . But once you got to know her you could see where that lack of judgment, that lack of understanding about her body . . . lack of ability to really discern . . . “I’m really having unprotected sex.”

Among those with more extreme learning disabilities or mental retardation, this was more clearly evident: “They don’t know anything about sexuality, about getting pregnant, about STDs, about what can get you pregnant. They think it’s from French kissing. I mean, really” (Kathy). This was complicated by misguided information: “And there’s just an unbelievably large amount of misinformation out there . . . Like how to get pregnant, how to get an STD, how to protect yourself from one” (Nathan). Finally, some chose not to use protection because of complacency (for example, “They’re just more passive” [Allison]), resignation (for example, “There’s almost like fatalism about it. Like, this happened to my mother and I know it’s going to happen to me” [Tamara]), or even a desire to become pregnant (for example, “Part of the problem I think is, you know, we get some girls who set out to get pregnant and we have some boys who set out to impregnate girls” [Beatriz]). Sometimes the adolescent girls viewed pregnancy as a solution to problems they were having, many as a result of the disability: “It becomes clear that there’s a part of them that wants to get pregnant and they’re trying. They’re seeing this as a good thing and as a solution in their life.” Allison went on to describe this as a result of their disability: “Well now I’m somebody’s mother and I have this cute baby in me and kinda fantasize about maybe what that role is gonna be.”

“I Might Be Pregnant”

Although more attention was devoted to the contexts in which adolescents with disabilities had sex and did not use protection, social workers’ knowledge of this often stemmed from discussions whereby the individual was already facing a potential pregnancy. Social workers discussed their roles as proactive in assessing risk (for example, “Many times I will hear rumors that girls are pregnant. If they’re my girls, I’ll ask them. They don’t know”

[Kathy]), talking to adolescents about contraception, and setting boundaries. They expressed frustration, however, at their inability to protect and educate each adolescent on their caseload, a difficulty enhanced by rapid escalation from kissing to intercourse. Ellen described this in the context of a student with learning disabilities, who did not comprehend the complexity and potential outcomes of sexual exploration:

And the romantic thing, so getting in trouble for kissing on campus . . . so it's like, "You shouldn't be holding hands, you shouldn't be . . ." and there's the question of "Are they pregnant or not pregnant?" And then you have to go to them, and with the learning disability sometimes they don't even understand what's happening.

Given a lack of support, Tamara described her role as critical: "They don't have anyone else they are talking to . . . there was no support other than talking to me." Students often turned to their social worker with questions about what to do next (for example, "I think I'm pregnant. I want to find out about getting an abortion. Where do I go? What do I do?") [Allison] or simply to express fear (for example, "Just this morning, I was working with a student who believes that he got a girl pregnant, so sometimes it's in that kind of crisis mode of pregnancy" [Nathan]). The latter was sometimes met with astonishment on the part of the social worker, given the frequency of this occurrence: "But the amazing thing is the amount of sexual activity that these teenagers are having. And the amount of 'Oh my God, I think I'm pregnant!'" (Rose).

"I'm Pregnant"

"You're too late." **"And we are standing with a second pregnancy."** Despite continued preventive intervention, social workers' attempts at discussing sex with youths were sometimes in vain, as Sam described: "I had one girl who I've worked with since she was a freshman and now she was a junior or senior, come to me with a neck of hickies on it. She says, 'You're too late. I'm pregnant.'" Once a social worker becomes aware that a student is pregnant, he or she is obligated to take on certain responsibilities; for example, "If a student comes

and they are positively identifying that they're pregnant, we have to notify their parents within 24 hours" (Rose).

Multiple social workers expressed frustration at repeat pregnancies among students. This was particularly challenging in the context of severe mental illness: "We have two kids who are both [disabled], one more than the other, but the boy is very mentally ill, I mean *very* mentally ill. Umm, and they got pregnant and she had a miscarriage and they got pregnant again within like a month" (Beatriz).

"It gets pretty complicated." Medications, abusive relationships, legality issues, and school dropout were each discussed as contexts through which pregnant adolescents with disabilities possessed additive risk factors that threatened both maternal and child health and well-being. Rose contextualized medical complications within a particular student's experiences:

But you know, when she was pregnant, she couldn't take her meds. And so, real erratic behavior . . . and then that's scary too when they—during those first months or weeks maybe when they didn't know they were pregnant and were on major meds. And then they have to go off their meds. And then they're dealing not only with the hormones of being a teenager, having a disability, not being able to manage their behaviors or their thoughts or feelings, and the hormones of pregnancy.

Some adolescents with disabilities were also dealing with dating violence while pregnant. Kathy described the relationship context of a particular couple on her caseload, in which the father of the baby was violent toward his pregnant girlfriend:

When she came in last week crying and discussing how he tried to choke her to death, I said to her once she was crying, "Did he do that to you?" She said yes. You think about it, that's for life. She's pregnant, on crutches, he tried to choke her. Where do you start with that?

In addition to helping adolescents cope with and respond to abuse, social workers sometimes helped adolescents and their family to deal with the complex layers of legality stemming from a pregnancy. Rose told of a pregnant adolescent whose major life

decision was embedded within the family contexts surrounding her disability:

“I really want to have this baby” and the family wanted her to do adoption and her not willing to do that. Of course, then there’s legal rights involved with that, and her brother was raising her, and it got really complicated.

Adoption was viewed by social workers as a positive alternative, given that keeping the baby placed added stress on the adolescent’s family, as well as increased the likelihood that he or she would drop out of school (for example, “We have a pregnancy issue. My group at the beginning of the year had 15/16 kids and a lot of them aren’t at school anymore because they couldn’t handle it” [Natalie]).

DISCUSSION

Social workers’ perspectives painted a picture of additive risk concerning the sexual and pregnancy experiences of adolescents with disabilities, including a perceived need to intervene early with appropriate and tailored sexual health information. Their focus on girls’ emotional vulnerability (that is, attention to low self-esteem, desires to engage in sex to fit in with peer norms) and cognitive barriers (that is, a tendency either to not understand potential outcomes of intercourse or to become caught up in the moment) highlights challenges that adolescents with disabilities face regarding sexual decisions and leading to pregnancy. Such socioemotional considerations are often neglected in adolescent sexual education (Stanger-Hall & Hall, 2011), but these findings suggest that ignoring such contexts may hold particularly affecting ramifications for adolescents with a range of disabilities. Furthermore, because of assumptions that they are “asexual” or at too high a risk to discuss (and supposedly encourage) sexual behavior (Blum et al., 1991; Shandra & Chowdhury, 2012), adolescents with disabilities may fall through the cracks where typically developing adolescents may receive multiple sources of potential influence (that is, from parents, doctors, and schools). Social workers in this study voiced that adolescents often came to them with pregnancy concerns, thus elucidating contexts of unprotected intercourse that may be used to inform the enactment of appropriate services for this underserved population.

Social workers felt the weight of their roles (for example, “You’re too late”) and expressed a desire to provide more support. Adams Rueda and Linton (2014) found, however, that there are many barriers to providing services, including abstinence-only policies and a lack of time to address individual sexual health needs. The Individuals with Disabilities Education Act (2004) mandates that public schools provide adapted education for youths with disabilities, although in abstinence-only climates, sexual health information may be unavailable even to adolescent populations without disabilities (Stanger-Hall & Hall, 2011). Moreover, school dropout rates point to a need to reach adolescents with disabilities early with comprehensive sexual health information delivered in a format that youths can both relate to and understand. Provision of such services would align with social work values of social justice, competence, and rights to client self-determination (NASW, 2008). Empowering adolescents with disabilities to make healthy relational and sexual decisions is complex, however, and particularly so for social workers who work with a range of disability types and answer to multiple systemic pressures (for example, school boards, parents; Adams Rueda & Linton, 2014).

It is interesting that a recent study points to adolescents with disabilities as often efficacious in predicting that they would experience teenage pregnancy (Shandra & Chowdhury, 2012), and some of the adolescents in the present study were similarly described as desirous of it. In some cases, then, perhaps social workers may need to shift their focus from pregnancy prevention to include family planning (Shandra, 2011), particularly given their reports of multiple pregnancies. Such attention should be directed to both males’ and females’ responsibility to the pregnancy. Although social workers value the use of a strengths and empowering perspective in practice, their professional education often does not address how to evoke such a lens when working with adolescents with disabilities (Laws, Parish, Scheyett, & Egan, 2010) and particularly concerning complex issues stemming from intersections of sexual intercourse, potential desires to parent, and a number of (often co-occurring) socioemotional and/or cognitive issues.

CONCLUSION

The goal of this study was to describe the pregnancy experiences of adolescents with disabilities from the

perspectives of school social workers. Social workers provided descriptions from their lived experiences in line with a phenomenological study design; however, the depth of understanding of the experiences with pregnancy of adolescents with disabilities is limited because adolescents themselves were not interviewed. Also, a broad definition of disability was used to capture the experiences of a diverse population of adolescents across disability type and level of severity. Although this is a notable limitation, this strategy mirrors social workers' all-encompassing roles; indeed, social workers described adolescents with disabilities in general terms as well (for example, "the high-profile difficult kids"), reflecting that youths often present with multiple and complex layers of (dis)ability and risk.

Findings point to school social workers as an invaluable resource for adolescents with disabilities who struggle with pregnancy and decisions concerning parenting. Although such adolescents are often protected from making decisions regarding their sexual health, they are engaging in unprotected sex, getting pregnant, and becoming teen parents. The unique needs of pregnant and parenting adolescents with disabilities solicit more formally designed interventions, although more research is needed to better understand how to provide them with appropriate sexual health services. It is likely that the role of social workers in providing these services will continue to be pivotal. Evaluation research will be increasingly needed. **HSW**

REFERENCES

- Adams Rueda, H., & Linton, K. F. (2014). School social workers' needs in supporting adolescents with disabilities toward dating and sexual health: A qualitative study. *Children & Schools, 36*, 79–90.
- Alriksson-Schmidt, A. I., Armour, B. S., & Thibadeau, J. K. (2010). Are adolescent girls with a physical disability at increased risk for sexual violence? *Journal of Social Health, 80*, 361–367.
- Blum, R. W., Resnick, M. D., Nelson, R., & St. Germaine, A. (1991). Family and peer issues among adolescents with spina bifida and cerebral palsy. *Pediatrics, 88*, 280–285.
- Centers for Disease Control and Prevention. (2011). Teen pregnancy: *The importance of prevention*. Retrieved from <http://www.cdc.gov/Features/VitalSigns/TeenPregnancy/>
- Cheng, M. M., & Udry, J. R. (2005). Sexual experiences of adolescents with low cognitive abilities. *Journal of Developmental and Cognitive Disabilities, 17*, 155–172.
- Greydanus, D. E., & Omar, H. A. (2008). Sexuality issues and gynecologic care of adolescents with developmental disabilities. *Developmental Disabilities, 55*, 1315–1335.
- Grover, S. R. (2011). Gynaecological issues in adolescents with disability. *Journal of Paediatrics and Child Health, 47*, 610–613.
- Individuals with Disabilities Education Act of 2004, P.L. 108–146, 118 Stat. 2647.
- Laws, J., Parish, S., Scheyett, A., & Egan, C. (2010). Preparation of social workers to support people with developmental disabilities. *Journal of Teaching in Social Work, 30*, 317–333.
- Martinez, G., Copen, C. E., & Abma, J. C. (2011). Teenagers in the United States: Sexual activity, contraceptive use, and childbearing, 2006–2010 National Survey of Family Growth. *Vital and Health Statistics, 31*, 1–35.
- National Association of Social Workers. (2008). *Code of ethics of the National Association of Social Workers*. Washington, DC: Author. Retrieved from <https://www.socialworkers.org/pubs/code/default.asp>
- Padgett, D. K. (2008). *Qualitative methods in social work research*. Thousand Oaks, CA: Sage Publications.
- Pownhall, J. D., Jahoda, A., & Hastings, R. P. (2012). Sexuality and sex education of adolescents with intellectual disability: Mothers' attitudes, experiences, and support needs. *Intellectual and Developmental Disabilities, 50*, 140–154.
- QSR International Pty Ltd. (2008). *NVivo qualitative data analysis software (Version 8)* [Computer software]. Melbourne, Australia: Author.
- Shandra, C. L. (2011). Life-course transitions among adolescents with and without disabilities. *International Journal of Sociology, 41*, 67–86.
- Shandra, C. L., & Chowdhury, A. R. (2012). The first sexual experience among adolescent girls with and without disabilities. *Journal of Youth and Adolescence, 41*, 515–532.
- Shearer, D. L., Mulvihill, B. A., Klerman, L. V., Wallander, J. L., Hovinga, M. E., & Redden, D. T. (2002). Association of early childbearing and low cognitive ability. *Perspectives on Sexual and Reproductive Health, 34*, 236–243.
- Stanger-Hall, K. F., & Hall, D. W. (2011). Abstinence-only education and teen pregnancy rates: Why we need comprehensive sex education in the U.S. *PLoS ONE, 6* (10), e24658.
- Swango-Wilson, A. (2011). Meaningful sex education programs for individuals with intellectual/developmental disabilities. *Sexuality and Disability, 29*, 113–118.
- Wiegerink, D. J. H. D., Roebroek, M. E., Donkervoort, M., Stam, H. J., & Cohen-Kettenis, P. T. (2006). Social and sexual relationships of adolescents and young adults with cerebral palsy: A review. *Clinical Rehabilitation, 20*, 1023–1031.
- Yampolskaya, S., Brown, E. C., & Greenbaum, P. E. (2002). Early pregnancy among adolescent females with serious emotional disturbances: Risk factors and outcomes. *Journal of Emotional and Behavioral Disorders, 10*, 108–115.

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