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Reproductive Autonomy for Individuals With Disabilities: Necessary Knowledge for Rehabilitation Counselors

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Reproductive autonomy, or the ability to make decisions about one's reproductive health, has been historically limited for individuals with disabilities. Within the last century alone, they have experienced forced sterilization, asexualization, negative stereotyping, and poor birth outcomes. Rehabilitation counselors can play a unique role in changing this harmful narrative and supporting the decision-making of their clients. As a field, rehabilitation counseling has often acknowledged considerations related to disability and sexuality, but gaps exist in the discussion of reproduction-related topics such as abortion care, fertility support, and the experience of pregnancy remain. The literature reviewed in this paper highlights the significance of these issues, particularly the historical and current disparities in access and need. Greater recognition, education, and advocacy regarding reproductive autonomy in rehabilitation counseling is necessary to ensure that practitioners are supporting clients in a supportive and appropriate way.

It is estimated that 61 million Americans have a disability (Courtney-Long et al., 2015), 10.6% of whom are of childbearing age (18-49; Kraus et al., 2018). Thanks to medical advances, legal protection of individuals with disabilities, and a decrease in stigmatization of disability, the number of people with reported disabilities in the United States is rising. Despite this promise, research indicates that reproductive autonomy, or the ability to make decisions about reproductive endeavors, is lacking. Barriers range from societal attitudes and stigma (Iezzoni et al., 2015) to poorer health care access for pregnancy and birth (Deierlein et al., 2021; Horner-Johnson et al., 2019; Iezzoni et al., 2013; Schiff et al., 2021; Walsh-Gallagher et al., 2012). When individuals with disabilities make decisions about their reproduction, they are forced to consider these factors in addition to thinking about general feasibility, cost, and other personal variables (LaPierre et al., 2017).

As defined by the Americans with Disabilities Act (Public Law 110-325, ADA), an individual with a disability has a diagnosis that limits more than one major life activity (e.g., walking, lifting things up, eating, dressing oneself). This can include a variety of diagnoses, from physical disabilities such as a spinal cord injury to chronic conditions such as diabetes. This definition, while specific, does not account for individuals with undiagnosed or self-diagnosed conditions that are still impactful but not legally recognized. Acknowledgement of these groups of individuals is growing (Dalhaug et al., 2023; Portway & Johnson, 2005); however,

for the purposes of this paper, the focus is on individuals with ADA-defined disabilities.

Regardless of disability type or status, disabled people continue to experience healthcare ableism, especially when seeking out reproductive support. In terms of contraceptive access, abortion care, and pregnancy-related experiences, this population experiences lower rates of access and satisfaction with services when compared to individuals without disabilities (H. K. Brown et al., 2019; Horner-Johnson et al., 2019, 2022). These limitations often stem from stereotypes and stigma. Healthcare practitioners, for example, report having limited knowledge of disabilities and how they impact the reproductive needs of their patients (Iezzoni et al., 2021; Taouk et al., 2018; Walsh-Gallagher et al., 2013).

Rehabilitation counselors (RCs) that support the independence and well-being of people with disabilities are crucial to the conversation of reproductive access and autonomy. Rehabilitation counselors value an intersectional and holistic approach to working with people with disabilities, a perspective reflected in the World Health Organization's (WHO) International Classification of Functioning, Disability, and Health (ICF) model (Chan et al., 2009; McNaughton et al., 2001). This model provides an integrative approach to conceptualizing disability in terms of key areas including activities and participation, personal and environmental factors, and general functioning. Personal and environmental factors include a broad range of variables including, but not limited to, gender, age, coping style, socioeconomic

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status, profession, education, technology access, natural environment, supports and relationships, attitudes, and/or available services, systems, and policies (Chan et al., 2009). Some of these factors, as they relate to reproductive autonomy experiences, will be reviewed, along with specific implications for rehabilitation counselors in supporting these individuals.

Notes on Terminology and the Literature Reviewed in the Paper

The terms woman or women are used throughout this paper. Much of the research referenced comes from fields with medical model perspectives which view gender and sex synonymously and does not recognize or discuss diversity within the category of ‘women.’ We acknowledge that this category and assumption is not inclusive of all the individuals impacted by the topics of this paper, particularly for those who do not identify as women and still have uteruses.

We also know that intersectionality, or the ways in which identities such as “gender, race, ethnicity, sexual orientation, gender identity, disability, class, and other forms of discrimination “intersect” to create unique dynamics and effects” (Center for Intersectional Justice, 2023), is relevant to the consideration of reproductive autonomy. Reproductive history for various marginalized identities is vast and diverse and will not be comprehensively covered in this article; for more discussion, see Maroto et al. (2019). There is evidence of the compounding effects of numerous identities both inside and outside of reproductive health care, including disability and race (Simons et al., 2021), disability and gender (R. L. Brown, 2014; Maroto et al., 2019); disability and SES (Doyle et al., 2020), and other identities. It is recommended to use caution when generalizing reported research to all identity categories, including those of different disabilities.

Few articles cited within this paper are from the rehabilitation field. There has been minimal research conducted around disability and pregnancy or reproductive access in the rehabilitation counseling literature. Rather, the reviewed literature comes from parallel and interdisciplinary fields, and highlights the negative narrative that continues to exist. Additionally, gaps in knowledge around reproductive health and access for those with disabilities are highlighted, emphasizing the need for additional research, education, and advocacy efforts specific to rehabilitation counseling.

Reproductive Education

Reproductive autonomy, or the ability for individuals “to be fully empowered agents in their reproductive needs and decisions and to access reproductive health services without interference or coercion” (Senderowicz & Higgins, 2020, p. 147), has not always existed for individuals with disabilities. The awareness of one’s reproductive autonomy begins with education. Reproductive education, often referred to as ‘sex education’ in public school settings, plays an essential role in individuals learning what reproductive rights and functioning they hold. This education has been

found to be directly linked to one’s self-concept and life satisfaction (Kriofske Mainella & Smedema, 2022). Despite its significance, reproductive education is challenging for individuals with disabilities to receive for numerous reasons including stigma from educators, removal from the mainstream classroom, and inaccessibility (Pebdani & Tashjian, 2022). Over the last few decades, as the legal rights of individuals with disabilities have increased, there is evidence of improvement, but many barriers remain.

Within the United States, decades of debate and research have revolved around sex education for disabled students, with no comprehensive, disability- or LGBTQ-inclusive approach being achieved (Hall et al., 2016; Tarasoff, 2021). Currently, decisions about implementation of sex education take place at the state, district, and school board levels, and often result in limited in-class time and resources being provided. The results of a 2022 survey showed that only 39 states mandate sex and HIV education within the U.S. (Guttmacher Institute, 2017). Of those 39, only 30 mandate specific requirements to be met when discussing sexual education, and only 10 require instruction to be provided in a way that is appropriate for and unbiased regarding race, sex, or ethnicity. The survey provides no information about sex or sexuality education for students with disabilities.

Reproductive and sexual education for individuals with disabilities has experienced increased attention in research and has identified lack of satisfaction and needs for improvement. Parents, educators, and health professionals have been found to feel uncomfortable, unprepared, and unqualified to provide sex education to adolescents with disabilities (Neufeld et al., 2002). Those feelings often stem from lack of disability knowledge, time limitations, inadequate training, and fear of negative reactions from others (Bloor et al., 2022; East & Orchard, 2014; Goli et al., 2022; Neufeld et al., 2002). As a result, disabled adolescents themselves often feel frustrated, unheard, and as if they are seen as a ‘non-person’ (East & Orchard, 2014). These individuals reported getting their education from the internet or discussion with peers instead. Meanwhile, parents reported feeling unsure of what to share with their children with physical disabilities or have focused discussions exclusively on safety and abstinence. Success has been found in disability-specific considerations for reproductive-related training and education, such as group menstrual care skills training for individuals with intellectual disabilities (Altundag & Çalbayram, 2016), the value of mainstream sex education for d/Deaf teens in school settings (Suter et al., 2012), and training workshops focused on building confidence in educators to support autistic youth in reproductive understanding (Curtiss & Ebata, 2016).

Healthcare Ableism

The remaining areas relevant to reproductive autonomy are frequently affected by the healthcare system. Unfortunately, evidence shows the United States healthcare system to exhibit high levels of ableism, or stigma, prejudice, and/or discrimination towards individuals with disabilities. This extends beyond simple avoidance of inclusive reproductive education and includes stigmatizing beliefs on who is wor-

thy of reproduction and parenting, inaccessible information and communication, and more (Graff & Russell, 2023). We see ableism in numerous areas of reproductive care including contraceptive access (Horner-Johnson et al., 2022), abortion care (Horner-Johnson et al., 2017; Kimport, 2022), prenatal services (Tarasoff, 2017), and pregnancy and birth (Darney et al., 2017; Walsh-Gallagher et al., 2012). What remains is low levels of satisfaction with reproductive services and reduced autonomy.

Contraception Care

Contraception use, or those interventions aimed to prevent or reduce pregnancy, have been studied on a limited basis with disability populations. Contraception use and effectiveness varies widely, with options including oral contraceptive pills, patches or rings, condoms, intrauterine devices (IUDs), vaginal douching, and/or calendar rhythm tracking. Historically, contraceptive use also included forced sterilization, a practice related to the eugenics movement in the 19th and early 20th century of non-consensual or coerced removal of reproductive organs for men and women, primarily those with intellectual disabilities or those deemed “feeble-minded” (Rowlands & Amy, 2019, p. 234). Laws prohibiting sterilization vary by country; the United States deemed sterilization illegal in 1942, but other countries did so much later (e.g., 1986 in Canada, 1992 in Germany, 2001 in France).

In today’s world, contraceptive access for individuals with disabilities has been examined on a limited basis. In the first article of its kind, Horner-Johnson et al. (2022) examined contraceptive use among adult women with various physical disabilities. Through qualitative research, five main themes emerged as challenges to receiving and accessing contraceptive access with a physical disability. First, accessibility of information was minimal, particularly for those with low-vision or who were blind. All resources were provided in printed format only. Secondly, women reported the information they were provided on the contraceptives was incomplete. For example, no information was provided on other options or possible side effects. The remaining barriers included clinicians lacking knowledge and competence around disabilities, the topic of contraceptives being taboo for some, and having limited time to make a collaborative decision on contraceptive access.

For individuals with substance use disorders, historical and current contraceptive access is also limited. Terplan and colleagues (2015) conducted a systematic review of 40 years of literature related to contraceptive experience for women with opioid and substance use disorders and found that they had higher rates of unintended pregnancy compared to women who do not use drugs. The authors also found that only half of women with opioid and substance use disorders used contraception, with condoms being the most common method. While research points to the alarming lack of support this population receives, no patterns were identified in the experiences of, or access to, contraceptive counseling.

Informed decision-making about contraceptive use is impacted by numerous factors. While Horner-Johnson and

colleagues (2022) found many clinical barriers, others have attributed contraceptive use decision-making to limited school-based sex education (Senders & Horner-Johnson, 2022). As noted, research in contraceptive use and access for those with disabilities is extremely limited and there may be additional factors influencing decision-making that have yet to be discovered.

Abortion

Abortion access and care is a highly politicized and culture-specific area of reproductive health, particularly following the increased abortion restrictions that have been implemented in many states in response to the overturn of *Roe v. Wade* in June, 2022 (*Dobbs v. Jackson Women’s Health Organization*, 2022; Kimport, 2022). Within the United States, each state has considerable control over abortion access and regulations, with 13 states having abortion bans in effect as of the end of 2022. Even more states have specific abortion restrictions in place, such as pertaining to the gestational age of the fetus or the number of appointments required prior to receiving the abortion (Kimport, 2022). The overturn of *Roe v. Wade* included exceptions to abortion access, including for when it is a medical emergency, or “to prevent death or irreversible damage to a major bodily function” (*Dobbs v. Jackson Women’s Health Organization*, 2022). These guidelines however are not always clear. For example, how ill does someone need to be to intervene? This has created an area of ambiguity and concern within the medical community (American College of Obstetricians and Gynecologists, 2022) with limited focus in research on its implications. Even less research has examined the post-*Dobbs v. Jackson* implications for parents seeking abortion due to disability in the fetus.

Kimport (2022) explored the decision-making and access experiences of numerous women, identifying key barriers that exist for marginalized communities seeking abortion.

Three key themes emerged in interviewing marginalized women on their abortion-related decisions. First, many women acknowledged the various structural barriers that made accessing abortion services challenging. These included Medicaid’s lack of coverage of abortions, finances, transportation, finding a provider who performs abortions, requirements of abortion clinics (e.g., requiring two appointments prior to receiving an abortion), and the rapid policy changes that “can give the impression that abortion care is unavailable when that is not the case” (Kimport, 2022, p. 51). A second theme was the numerous cultural narratives about what abortions are and their meaning. For some women, going through with a pregnancy was viewed as “taking responsibility” for getting pregnant in the first place (p. 88). For others, a narrative existed that receiving an abortion would cause harm, despite there being no evidence of abortions leading to anxiety, depression, or other negative mental states (Charles et al., 2008; Warren et al., 2010). Lastly, the role of social context was evident for numerous interviewees. Abortion was eliminated as an option for some based on their family and friends’ opinions on abortion, especially when the women were dependent on others for financial support. The same social context some-

times limited and biased the abortion information provided to women. While participants primarily identified as low-income and/or Black, these identities are likely to be held by some disability group members as well.

Horner-Johnson and colleagues (2017) conducted the first examination of abortion rates among women with disabilities, highlighting the additional challenges this population faces. In a sample of 30,000 women with and without disabilities, the highest rates of abortion occurred among women with complex and basic activity limitations. More recent disability-specific statistics have emerged focusing on those with schizophrenia. Brown and colleagues (2019) found women with schizophrenia to have higher abortion rates than those without schizophrenia, with increased ratios among those in younger age groups (15 to 24 years old) and those with comorbid mental illness or substance use disorders. All the abortion-focused research acknowledges that abortion is often underreported for a variety of reasons and estimates the rates of abortion to be higher than reported (H. K. Brown et al., 2019; Horner-Johnson et al., 2017).

Fertility & Infertility

Few articles have examined infertility among those with physical disability, and none have examined their experiences with infertility support. A study conducted by Zhang et al. (2019) examined the infertility and fecundity-probability of conceiving within a menstrual cycle for a person having regular unprotected intercourse among those with and without disability. Individuals without a disability had higher education levels, were more likely to be insured, and spent fewer months trying to get pregnant. Despite this, the statistical analysis showed no difference in fecundity (i.e., the ability to produce offspring) among individuals with or without disabilities. With numerous limitations to this study, it is the first of its kind looking at disability and infertility.

Prenatal Care & Decision Making

Prenatal care, or support and experiences before birth, involves supporting individuals in identifying pregnancy intentions, discussing contraception and fertility, identifying factors associated with high-risk pregnancy, and providing education related to pregnancy (American Academy of Pediatrics, 2017). Prenatal care is recognized as one of several factors that influence birth outcomes for individuals with disabilities (Horner-Johnson et al., 2022). The AAP and ACOG (2017) have established standards for supporting individuals through the pre-pregnancy experience, including assessing intentions to become pregnant and conducting health screenings. Specifically, it is recommended that practitioners engage in supportive conversation that may include:

- An evaluation of her overall health and opportunities to improve health,
- Education about the important effect that social, environmental, occupational, behavioral, and genetic factors have on pregnancy,

- Identification of factors associated with high risk of an adverse pregnancy outcome, with interventions recommended to provide a women's risk profile before pregnancy. (AAP, 2017, p. 131)

Although these guidelines appear thorough, in practice, those with disabilities rarely experience such support. Survey data between 2002-2011 suggested that women with disabilities were less likely to receive prenatal care within their first trimester and more likely to have adverse pregnancy outcomes (i.e., low-birth-weight babies, preterm birth, and pregnancy complications; Mitra et al., 2015). O'Connor-Terry & Harris (2022) interviewed 16 cisgender women with physical disabilities and found that most of them were under the assumption they were simply infertile.

The literature on pregnancy experiences suggests that practitioners are unprepared to work with women with specific disabilities. Horner-Johnson et al. (2022) found patterns among prenatal care by disability type. Specifically, individuals with intellectual and developmental disabilities (IDD) experienced greater disparities than other disabilities; they were the least likely to receive care within the first trimester and were more likely to have specific considerations around pregnancy detection and important intersecting health conditions (e.g., smoking and/or obesity). Those with physical disabilities were least likely to reach out for prenatal care, primarily due to concerns of accessibility. Tarasoff's (2017) finding among 13 women with physical disabilities supported this; most women reported their prenatal care was provided by practitioners who had minimal understanding of the disability, including a participant reporting they were told, "we've never had anybody like you before" (p. 429). Additionally, individuals encountered providers who had generally negative attitudes about disability and pregnancy, and their care was received in a location that lacked accessible spaces and tools (e.g., inaccessible examination tables and inaccessible bathrooms with handrails, chairs, or walkers).

Pregnancy Experiences

The deep-rooted assumptions and stereotypes around disabilities and sexuality have spread to stigmatizing attitudes within the general population, including healthcare professionals, friends, and family. Iezzoni and colleagues (2015) interviewed 22 women throughout the U.S. with physical disabilities who delivered babies within the 10 years prior to determine responses they encountered from the public. The women in the study used assistive devices for mobility, including wheeled mobility aids such as wheelchairs. Six common responses were received from strangers related to their pregnancies or newborn infants including: (a) curiosity, (b) intrusive and persistent curiosity, (c) hostility, (d) questioning competence as a potential parent, (e) oblivion, and (f) positivity. Five out of the six responses can be interpreted as negative, especially when reviewing the specific examples given by the women in the study. One woman was asked by a stranger if she was raped when referring to her current pregnancy, implying nobody would voluntarily have sex with her. Another woman expe-

rienced pure disgust from a stranger who asked her, “someone would have sex with you?” (Iezzoni et al., 2015). Some comments, however, were positive and included words of kindness, as well as those that were complimentary and celebratory.

Similar experiences were reported by Powell and colleagues (2017), who examined family and friend reactions to women with physical disabilities announcing their pregnancies or their interest in becoming pregnant. The attitudes and reactions were categorized into six themes, five of which were negative. For example, the women were questioned about their parenting abilities, with the added concern of genetics (e.g., “will the baby be at risk of inheriting the mother’s disability?”). Parenting capabilities were questioned further, including questions about how mothers were going to get everything done, including putting the child in the car. A small portion of women in the study reported excitement and support from their family members, whereby they looked forward to the addition to the family and offered support, but most responses continued to be negative.

Both studies, as well as many others, examined the attitudinal barriers and judgements experienced by women with physical disabilities throughout their pregnancy journey by outsiders (Iezzoni et al., 2015; Powell et al., 2017; Tarasoff, 2015). Research on pregnant women with physical disabilities on an even larger scale shows numerous examples of these women being made spectacles of. Articles and news stories on the Today Show and CBS News feature women with physical disabilities who were pregnant or having babies and sharing their experiences (Anderson, 2019; Bernabe, 2020). While these stories may intend to educate individuals that disabled women can and should experience pregnancy, it may also be perpetuating the idea of women with disabilities as ‘inspirational.’ If these experiences were not something to be questioned, or made a spectacle, they would not be on the news at all.

Birth and Birthing Care

While birth experiences vary for every woman, those with disabilities have shown patterns of poorer birth outcomes. Compared to women without disabilities, those with disabilities are more likely to experience preterm and/or caesarean deliveries (Darney et al., 2017). While most researchers do not examine the specific circumstances of each woman, those with physical disabilities were acknowledged as presenting unique challenges during delivery which may be related to some of the risks and delivery choices. No matter the case, women with various disabilities have reported that the decision about delivery method was made without their input and/or without consideration of other methods (Smeltzer, 2007).

Researchers have looked at the educational preparation healthcare providers receive regarding the prenatal care and delivery of women with disabilities, particularly those with physical disabilities. Prior to even beginning the discussion of birth, many practitioners have admitted that they hold stereotypical views of individuals with disabilities, having no experience working with them at all, preg-

nant or not (Walsh-Gallagher et al., 2013). Healthcare workers are meant to help any individual that comes into their care. If they hold stigmatizing views, the care could be compromised. Additionally, the same study found that, among hospital personnel including midwives, social workers, nurses, and managers, most of them noted ambivalent attitudes around working with pregnant women with physical disabilities and lacked knowledge about disabilities in general (Walsh-Gallagher et al., 2013). The same results were found by Smeltzer and colleagues (2018), who concluded that most clinicians receive training for this population from hands-on experience only.

Limitations to Research

Throughout the various topics regarding the reproductive experiences of disabled women discussed in this paper, the literature reviewed provided insight, but also reflected specific limitations. For most articles, the definition of a physical disability was consistent, however not all researchers utilized the same disabilities within their samples when generalizing to the larger ‘women with physical disabilities’ population. For example, most studies were focused on women with multiple sclerosis or spinal cord injuries, while others included other disabilities such as blindness or cerebral palsy. It is important to note the populations used when considering their experiences. The experiences of a blind individual versus one with a spinal cord injury may be vastly different (Schiff et al., 2021).

Second, the populations examined in many studies may pose significant barriers when thinking about a study’s generalizability. While not explicitly stated, it is assumed that most studies included cisgender women, many of whom were White and/or Caucasian. The conversation related to disability and reproductive autonomy should not exist without acknowledgement of other marginalized identities, particularly related to race and ethnicity. It is recognized that other marginalized identity groups have their own reproductive rights history (Nelson, 2003), a history of which that often intersects with disability history. Rehabilitation counselors who follow an intersectional approach should consider if, where, and how these identities influence each other.

Third, no studies specifically included a diverse gender-identity population. Uterus-owning is not exclusive to those who identify as female; some transgender men are often still able to achieve pregnancy. As of today, there are no reliable statistics available on the number of transgender men who are pregnant, have carried a child, and/or have given birth. Recent research by Riggs et al. (2020) examined the experiences of men, trans/masculine, and non-binary individuals with pregnancy loss in numerous countries, finding there is minimal research on the experiences of non-cisgender individuals and pregnancy. Results showed that this population experiences a narrative that their body is wrong, and they have failed. Most research articles reviewed for this paper did not confirm the gender identity of participants, aside from labeling them as ‘women.’ This language alone inherently excludes the possibility of other gender identities. While some have worked

to shift language from ‘mothers and women’ to gender-neutral terms, not everyone has acknowledged or agreed upon this change (Reis, 2020).

Lastly, pregnancy experiences and rights have been, and continue to be, influenced by politics. Politics play a role in what access there is to abortion and contraception, and for whom. It is necessary to acknowledge the political context of research, particularly when it impacts access to reproductive care for individuals. Most of the articles cited in this review were published prior to the United States Supreme Court’s decision to reverse *Roe v. Wade* in June 2022’s court case of *Dobbs v. Jackson*, eliminating the decades-long constitutional right to an abortion within the United States. This change in legal protection has direct implications for the experiences of individuals with disabilities in the United States. While none of the reviewed articles discussed the political landscapes that may have impacted experiences, considering past, present, and future political climates will help frame the context of reproductive experiences of individuals with disabilities.

Implications for Rehabilitation Counselors

Education

The chances of working with a pregnant or parenting individual with a disability is high, particularly for those working in disability-specific contexts such as rehabilitation counseling. As with any professional who feels uninformed or incompetent in a specific disability-related area, education is an important starting point. As of 2022, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) does not require education on reproductive health experiences (CACREP, 2016). Marriage, couple, and family counseling programs do require knowledge and practice regarding parenting, without acknowledgement of the variables that lead to parenting including reproduction. It may be the case that these topics are covered within individual-program contexts but without standards requiring it, knowledge acquisition for counselors remains inconsistent.

Lack of knowledge for counselors is evident in numerous areas including infertility, contraceptive access, and understanding abortion, birth, and postnatal care, based on its highly limited discussion in major rehabilitation journals. Counselors and mental health professionals should consider the implications of these topics when working with clients in various settings. Conversations of relevance to rehabilitation counselors may include, but are not limited to, pregnancy/parenting rights and resources in the workplace, social stigma of pregnancy and parenting on quality of life, barriers to accessing care, and political influence on reproductive autonomy.

Education needs extend to knowledge of intersectionality and relevant history for various identities. For rehabilitation counselors in CACREP-accredited programs, limited acknowledgement exists on topics of intersectionality, history of marginalized identities, and social justice topics such as reproductive autonomy (Council of Counseling and Related Educational Programs, 2016; Pieterse et al., 2009).

We have even less knowledge on what discussion of these topics looks like in educational settings, if at all. With the profession’s value of supporting individuals holistically and with an intersectional approach, education on such identities is necessary. This includes diverse gender, race, and ethnic identities and their specific history of marginalization in health care and other relevant contexts.

Vocational Counseling

For rehabilitation counselors working in vocational settings, knowledge of legislation related to return-to-work and reproductive needs is necessary. The Family and Medical Leave Act (FMLA) of 1993 provides legal protection to employed women and continued medical coverage for 12 weeks surrounding childbirth. Specific eligibility criteria must be met for an individual to be covered by FMLA (Family and Medical Leave Act of 1993, 2006), including: (1) having worked for the last year for at least 1,250 hours, and (2) working for an employer who has 50 or more employees. While some research has found the passing of FMLA to be highly beneficial to women, particularly compared to previous years when paid leave for reproductive needs was nonexistent (Schott, 2012), others have found this legislation to be highly limited in its benefit for many individuals. For many low-income individuals, FMLA is simply not available due to the type of work or employer (Hedden, 2020). Rather, they are forced to quit their jobs, rely on partner for familial income, or return to work earlier than planned. Other variables, such as age or disability status, may impact an individual’s decision to return to work at all (Neary et al., 2019). Limited research exists on FMLA’s use for reproductive needs other than pregnancy or birth, such as abortion or miscarriage. As rehabilitation counselors support clients in finding and maintaining employment, familiarity with FMLA and other relevant time-off legislation is necessary. Additionally, rehabilitation counselors may help support the decision-making process related to return-to-work due to reproductive needs based on the specific circumstances and identities of each client.

As a rehabilitation counselor, whether working in a vocational setting or not, it will be important to continue to monitor one’s own “cultural background, experiences, sociopolitical position” as it relates to supporting reproductive autonomy for individuals with disabilities (Commission on Rehabilitation Counselor Certification, 2023, p. 14). Certified rehabilitation counselors (CRCs) have an ethical responsibility to ensure their personal values are not imposed on clients. Many reproductive autonomy topics, such as abortion, remain highly political. Additionally, some CRCs have expressed client autonomy in general to be an area of ethical challenge (Hill et al., 2023). How and when rehabilitation counselors are navigating reproductive autonomy conversations remains unknown and remains an important consideration for future work.

Advocacy and Community Connection

Social support is a key factor for individuals with disabilities, directly impacting their sexual self-concept (Kri-

ofske Mainella & Smedema, 2022), their access to and understanding of abortions (Kimport, 2022), and the support a pregnant individual may experience (Powell et al., 2017). A large role of rehabilitation counselors is to serve as advocates for the rights of individuals with disabilities in various contexts, with reproductive rights being no exception. Advocacy efforts in this area will depend on the context in which rehabilitation counselors are working but may include directly addressing incorrect or biased information about individuals with disabilities and/or advocating for the reproductive rights these individuals deserve.

Advocacy efforts may begin with connection to both national and local organizations that support reproductive equity for individuals. For example, SisterSong, a national organization working to “improve institutional policies and systems that impact the reproductive lives of marginalized communities” is based on principles of reproductive justice (SisterSong, 2023). Reproductive justice, a concept developed by 12 Black women in 1994 who later formed SisterSong, believes in values of human rights—that everyone has the right “not to have children using safe birth control, abortion, or abstinence; the right to have children under the conditions we choose; and the right to parent the children we have in safe and health environments” (Ross et al., 2017, p. 14). The values of reproductive justice strongly overlap with concepts of disability justice, believing that all bodies are unique, important, and valued, with intersectionality considerations being essential (Sins Invalid, 2019). Disability justice is an emerging theme in numerous helping professions including rehabilitation counseling (Eiler & D’Angelo, 2020). Finding local organizations that exhibit similar values, actions, and advocacy efforts will help support rehabilitation counselors’ ability to engage in advocacy work and refer clients most appropriately.

Future Research

Numerous gaps in understanding reproductive autonomy and experiences for individuals with disabilities need to be examined further, including, but not limited to: sex education for individuals with disabilities (East & Orchard, 2014); infertility care for individuals with disabilities (Zhang et al., 2019); the impact reactions from society, strangers, and loved ones have on the pregnancy experience; resources that may be useful in providing an accessible birthing experience such as a doulas, midwives, or other birth support; the experiences of the postpartum period for individuals with physical disabilities; and the experiences of pregnant women with physical disabilities and other intersecting identities. As the profession of rehabilitation counseling works to rewrite the narrative and examine the lived experiences of individuals with disabilities, it

will be important to continue research in these areas to see what, if anything, is changing. There are clearly areas that need improvement, specifically around healthcare ableism, what specifically is being implemented or attempted, and impact this is having on individuals. In these instances, it will be important to hear from people with diverse disabilities and identity categories to hear what is and is not working and to make change accordingly.

Most of the research in this paper came from examination of cisgender, Caucasian individuals with apparent, or physical, disability types. No studies specifically included individuals with nonapparent, or invisible, disabilities. With research supporting disparate experiences, stereotypes, and support for those with apparent vs. non-apparent disabilities in society, it will be important to examine whether that extends to pregnant bodies as well. Examining these differences may show the inherent bias between apparent and non-apparent disabilities and help the profession rewrite the narrative more inclusively. Additional research is needed to examine experiences of other intersecting identities including gender and race/ethnicity.

Lastly, while this paper and much of the research explored has shown the inherently negative narrative that exists, there should also be space to highlight the positive changes and improvements within the last several decades. With recent legal changes, focus has often been on what has been lost and taken away, as opposed to positive changes that have resulted. Various efforts already have created change on numerous levels. Nationally, the CDC’s Division of Reproductive Health (DRH) celebrated their 50th year of medical advances in 2017 (DRH, n.d.). Community levels are seeing increased reproductive justice advocacy efforts, bringing the conversation of reproductive autonomy back into mainstream news. While change feels small and slow, these developments should not go without notice.

Conclusion

The reproductive experiences of individuals with disabilities are often filled with barriers, limited resources, and poor support. Stemming from deeply rooted history, the narrative around this population persists in the attitudes held by strangers, family members, and healthcare professionals. Professionals have also been found to lack training and understanding of the needs of the population of disabled individuals. As rehabilitation counselors who value a holistic approach to supporting clients, the lack of reproductive acknowledgement in literature and education leads to further concern. Through increased exposure and discussion, the current structure of support for these individuals in numerous contexts can be changed for the better.

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