

Pregnancy, Abortion, and Motherhood: Does Disability Matter?

By
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B.S., Sociology, 2017

Submitted to the graduate degree program in the Department of Sociology and the Graduate Faculty of the University of Kansas in partial fulfillment of the requirements for the degree of Master of Arts.

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Date Defended: 26 April 2019

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Date Approved: April 26, 2019

Abstract

Women with disabilities are classified as “risky” mothers and are encouraged by healthcare providers to not have children. Societal notions about who are appropriate mothers create barriers for women with disability who desire to have children. This study focuses on motherhood and pregnancy as one facet of WWD’s lived experiences. Using data from the National Survey of Family Growth, which included a sample size of 11,285 women, I analyze the effect of having a disability on attitudes about motherhood and likelihood of having ever pregnancy, and ever receiving an abortion. In contrast to previous studies (Horner-Johnson et. al. 2016; Shandra et. al. 2014), analyses show that women with disabilities are less likely to agree that having children are necessary to be happy compared to able-bodied women. Women with disabilities had 1.45 times the odds of ever having had an abortion compared to able-bodied women. Having a disability was found to not be a significant predictor of pregnancy or utilization of fertility services.

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INTRODUCTION

“[D]isability is the most human of experiences, touching every family and – if we live long enough – touching us all” (Garland-Thomson 2011: 17).

Women with disabilities¹ (WWD) face stigma and discrimination due to their impairments in a variety of situations: when seeking employment, housing, healthcare, and education (Aranda 2015; Rothstein 2015; Becker, Stuifbergen, and Tinkle 1997; Vornhold, Villotti, Muschalla, Bauer, Colella, Zijlstra, Van Ruitenbeek, Uitdewilligen, and Corbiere 2018). WWD also face barriers to physical and symbolic spaces, primarily due to notions of compulsory able-bodiedness which make some spaces inaccessible to WWD (McRuer 2006; Becker, Stuifbergen, and Tinkle 1997). Compulsory able-bodiedness is a hegemonic assumption that most bodies are “normal” and able-bodied; thus, notions of compulsory able-bodiedness views impaired bodies as being deviant and undesirable (McRuer 2006; Mollow and McRuer 2006). Disability studies scholars argue compulsory able-bodiedness is articulated through societal structures that are not accessible to WWD and hegemonic ideals that see disability as a characteristic that is problematic and should be avoided (Kafer 2003). Compulsory able-bodiedness has spurred the rise of ableism, which is any form of oppression imposed on persons with disabilities due to their impairments (Thomas 2007). Through these mechanisms compulsory able-bodiedness shapes the lived experiences of WWD.

Notions of compulsory able-bodiedness affect WWD, especially when trying to attain motherhood. In developed capitalist societies, childbearing has become an option for most women as opposed to an inevitable fate (Thomas 1997). Most women, particularly white middle-class women, have the option to choose if and when they have children (Ross and Solinger 2017). However, societal norms of compulsory able-bodiedness marginalize and make invisible

individuals. These norms attempt to exclude WWD from attaining motherhood (McRuer 2006); while WWD may want to have children, they do not have the same freedom as other women to choose if and when they have children. From a young age, WWD are subjected to compulsory ideas about what defines “normal” bodies (Prilleltensky 2004). WWD are excluded from sex education and are told they are undesirable partners (McRuer 2006; Mollow and McRuer 2006; Vaughn, Silver, Murphy, Ashbaugh, and Hoffman 2015). As WWD grow up, they receive messages from parents and healthcare providers that they will not find partners or have children (Prilleltensky 2004). While studies document the particular challenges faced by WWD, such as women with spinal cord injury (Dillaway and Lysack 2014) or Huntington’s disease (Klitzman, Thorne, Williamson, Chung, and Marder 2007), no study compares the rates of pregnancy across multiple diagnosis-specific types of disabilities. A study, which divided disability into the categories of vision, hearing, physical, cognitive, and multiple disabilities, found that women with multiple disabilities were significantly less likely to have ever been pregnant compared to able-bodied women (Horner-Johnson et al. 2016). The study found no significant difference in the proportions of women in the other disability categories who had been pregnant compared to able-bodied women.

Even though WWD are told they should not have children, women with physical and intellectual disabilities have similar motherhood desires compared to able-bodied women (Shandra, Hogan, and Short 2014). However, WWD face many barriers to motherhood that able-bodied women do not experience; societal preferences for able-bodied persons extend beyond capitalist work practices, pervading individuals’ ability to have sex and become parents (Prilleltensky 2004). Hegemonic cultural ideals about motherhood are perpetuated through some healthcare provider’s unsupportive attitudes about WWD having children (Frederick 2017).

Existing literature posits WWD face medical facilities that are inaccessible and medical providers who are unsupportive and unknowledgeable about their reproductive health needs and desires (Morales, Gauthier, Edwards, and Courtois 2016; Bernert 2011; Becker et al. 1997). Such barriers make attaining motherhood difficult for WWD.

When WWD get pregnant, they face barriers to having a pregnancy that ends with a live birth. Through the rise of genetic testing technologies, it has become common practice for healthcare providers to screen fetuses for genetic impairments and diseases (Asch 2003). Since notions of compulsory able-bodiedness socialize individuals to devalue impaired bodies, some physicians counsel women to abort fetuses which may be born with deformities (Frederick 2017). Even though their impairments may not be inheritable, WWD are assumed to be more likely to give birth to babies with impairments (Thomas 1997); thus, it is not uncommon for healthcare providers to counsel WWD to receive abortions (Frederick 2017). While WWD's narratives about being counseled to receive abortions has been documented qualitatively (Horner-Johnson, Darney, Kulkarni-Rajasekhara, Quigley, and Caughey 2016), no studies have investigated the relationship between having a disability and receiving abortions.

This paper will focus on motherhood and pregnancy as one facet of WWD's lived experiences. In this study I will analyze the relationship between having a disability on women's attitudes about motherhood, pregnancy, and abortion. This study adds to the body of literature on disability and motherhood by using recent data, spanning six years, to compare pregnancy among WWD and able-bodied women and to examine the relationship between having a disability and women's attitudes about motherhood. I will also the relationship between having a disability and fertility service utilization. Lastly, I will evaluate the odds of having an abortion for WWD and able-bodied women.

THEORETICAL FRAMEWORK

Historically, disability issues have predominantly been viewed one of two ways: situated with-in the medical-versus-social model of disability debate, or through the lens of feminist disability studies. While each of these perspectives adds to scholarly conceptions of disability, they tend to ignore the intersectional nature of disabled identities and societal notions that shape these identities. In this section, I will provide an overview of the medical and social models of disability, move to a discussion of feminist disability studies, and then describe how feminist disability studies overcomes the shortcomings of the social model by adding an intersectional approach to studying disability.

Medical and Social Models of Disability

Two competing models of disability are used to understand what disability is, how it should be classified, and what persons with disabilities experiences are like. These two models are known as the medical model of disability and the social model of disability. Medical professionals tend to adopt a medical model of disability, while some social scientist and disability activist tend to adopt a social model of disability (Beaudry 2016).

The medical model of disability states disabilities are characteristics of individuals involving the malfunction of an organ/appendage, which requires medical treatment (Seger 2018). This model views disability as a tragedy that medical experts are responsible for defining and treating (Beaudry 2016). While the medical model remains prevalent in biomedical sciences literature, the model has received criticism from social scientists for ignoring the social and environmental factors that effect and cause disability (Beaudry 2016; Bricher 2000).

The social model posits disability is a socially constructed phenomenon grounded in ableist ideologies (Anastasiou and Kauffman 2013). The social model of disability opposes the medical model of disability by stating disability is a product of broad social and economic structures instead of bodily pathology (Anastasiou and Kauffman 2013). Proponents of the social model problematize the acknowledgement of differing bodies discussed by the medical model and opts for the dissolution of these categories (Terzi 2004). According to the model, disability is not a tragedy; there is nothing inherently wrong with people with disabilities and their conditions do not always require ongoing medical treatment. Instead, social structures that do not provide adequate resources and services needed for persons who experience disability to participate in social activities are at fault (Anastasiou and Kauffman 2013).

The social model clearly dichotomizes and defines “impairment” and “disability”. An impairment is a bodily dysfunction. A disability is a socially constructed condition that occurs when an individual with an impairment is not properly accommodated and, as a result, is excluded from various activities or spaces (Anastasiou and Kauffman 2013; Oliver 1996). Thus, the social model posits disability is not caused by the “deviant” bodies of persons with impairments, but rather by the failure of society to accommodate persons with impairments.

The social model’s conception of disability might explain the experiences of individuals with prototypical physical disabilities, such as the loss of an arm from an automobile accident since these individuals are biologically “normal” aside from their missing limb; yet, such individuals are labeled as disabled and may have difficulty accessing services, spaces, and experiences due to their impairment. However, by focusing on the social nature of impairments, the social model of disability ignores the experiences of individuals whose impairments need

medical treatment, such as individuals who rely on an insulin pump to manage their diabetes, and individuals whose impairments impose social restrictions (Terzi 2004).

Feminist Disability Studies

Feminist Disability Studies² builds off the social model of disability to provide a critique of essentialist biological conceptions of gender and disability present in the medical model of disability and some branches of feminism. Feminist Disability Studies adds to the social model of disability by examining the way in which having a disability affects women. While feminist disability scholars acknowledge a range of bodily diversity exists and creates different experiences of disability, they avoid using impairment specific labels to discuss disability (Garland-Thomson 2005). Instead, scholars aim to highlight the collective voices of PWD by studying the meanings assigned to disabled bodies, particularly at the intersection of gender and disability (Terzi 2004; Hall 2011).

Operationalization of Disability

While the social model of disability has limitations, it has been used by medical sociologist and other health scholars to operationalize disability in survey research. By employing the social model and its definitions of impairment and disability, the World Health Organization (WHO) developed the International Classification of Functioning, Disability, and Health (IFC) (Brandt, Ho, Chan, and Rash 2014). This IFC expands the definition of disability provided by previous conceptions of disability. IFC operationalizes disability as “an umbrella term for impairments, activity limitations or participation restrictions” (Linden 2017, pp. 126; World Health Organization 2001).

The IFC is a document that “conceptual[izes] [the] understanding of disability, recognizes disability as the outcome of the interaction between a person with a health condition and contextual factors (both environmental and personal)” (Brandt et al. 2014, pp. 2664). In the IFC, the WHO acknowledges the relationship between impaired bodily structures and functions, and activity limitations and participation restrictions (World Health Organization 2001). Activity limitation is defined as difficulty seeing, hearing, walking, or problem solving. Participation restrictions refer to limitations of a person’s involvement in activities such as working, engaging in social activities, and obtaining health care services (World Health Organization 2001). The purpose of IFC is to help physicians select the most beneficial intervention that addresses medical and social aspects of an individual’s impairment (Seger 2018). The WHO states there are many types of disabilities, such as those which affect an individual’s hearing, vision, movement, thinking, remembering, learning, communication, mental health, and social relationships (World Health Organization 2001). Disabilities can be further classified as being present at birth, associated with developmental conditions, related to an injury, or associated with a chronic condition (World Health Organization 2001). However, when operationalized in social sciences research, disabilities are generally categorized as a physical disability or an intellectual disability.

DISABILITY AND MOTHERHOOD

Dominant social structures and institutions are organized in ways that create and reify ableist ideologies and limit access for persons with disabilities (PWD) (McRuer 2006). Even though WHO mandated sexual health as a human right in 1948, PWD are often excluded from sex education and lack access to adequate healthcare because they are stereotyped as being asexual (Mollow and McRuer 2012; Lofgren- Martenson 2012; Becker et al. 1997; Bernert 2011;

Lofgren-Martenson 2012; Vaughn et al. 2015). While WWD may lack information about sex and reproductive health, research reports WWD have similar desires for motherhood compared to able-bodied women (Bloom, Mosher, Alhusen, Lantos, and Hughes 2017; Shandra, Hogan, and Short 2014). One study found sixty-one percent of WWD reported they wanted another baby compared to sixty percent of able-bodied women, indicating no significant difference between desires for motherhood among WWD and able-bodied women (Bloom et al. 2017).

While WWD may desire children, they are significantly less likely than able-bodied women to intend to have a baby in the future (Bloom et al. 2017; Shandra et al. 2014). Bloom and colleagues (2017) reported only forty-three percent of WWD intended to have a baby in the future compared to fifty percent of able-bodied women. This finding also holds true from women who already have children; on average, WWD who are already mothers are more likely to want another child but are less likely to intend to have another child compared to able-bodied women (Shandra et al. 2014).

Many WWD receive messages from parents and health professionals that they will not find marriage partners or become capable parents (Prilleltensky 2004; Thomas 1997; Frederick 2017). In her in-depth interviews with thirteen women with physical disabilities, Prilleltensky (2004) found it was common for WWD to report their parents being unwilling to acknowledge their sexuality and discuss dating and safe sex practices. WWD do not receive adequate sex education, which limits these women's knowledge of healthful sexual practices, contraceptive use, and pregnancy (Bernert 2011, Becker et al. 1997; Brown and Pirtle 2008; Vaughn et al. 2015). As a result, these women have inadequate access to contraceptive and are less likely to engage in healthful sex practices, putting them at increased risk for unintended pregnancy (Mosher et al. 2018).

Not only does disablism affect WWD's access to information about healthful sex practices, it also influences their ability to become mothers (Thomas 1997; Prilleltensky 2004; Vaughn et al. 2015). WWD receive discouraging messages about their reproductive health and chances for motherhood (Prilleltensky 2004; Thomas 1997; Frederick 2017; LaPierre et al. 2017; Wu, McKee, McKee, Meade, Plegue, and Sen 2017). Some WWD reported not discussing the possibility of motherhood with their parents because of anticipated disapproval; other women stated their parents questioned their ability to adequately care for children (Prilleltensky 2004). As a result, women may become socialized to the idea that they will not have children and construct their gendered identities through other roles.

Issues about attaining motherhood extend beyond conversations WWD have with family members to include messages WWD receive from physicians. Literature indicates healthcare providers' unsupportive attitudes about WWD being mothers significantly influences WWD's pregnancy intentions (Shandra et al. 2014; LaPierre et al. 2017; Thomas 1997). WWD report being advised by healthcare providers not to get pregnant, even when pregnancy is technically possible (LaPierre et al. 2017; Thomas 1997, Vaughn et al. 2015). In some instances, healthcare providers impose their own biases about disability and motherhood on WWD whose impairments physicians deem severe (LaPierre et al. 2017; Vaughn et al. 2015). While this is unethical it occurs because physicians want to minimize the risk to the patient and some physicians view WWD as high-risk for pregnancy complications. Literature indicates healthcare providers also discourage WWD whose impairments are not severe enough to impact their ability to care for children to not get pregnant, such as Deaf women (Thomas 1997; Frederick 2017; Prilleltensky 2004).

Parents' and physicians' attitudes about WWD engaging in sex and being mothers echo broader societal notions of motherhood. While WWD's desires for motherhood are comparable to women without disabilities, the medical model problematizes disabled bodies and the women who inhabit them as "risky" mothers (Thomas 1997; Frederick 2017; Shandra et al. 2014; LaPierre et al. 2017; Bloom, Mosher, Alhusen, Lantos, Hughes 2017). In her interviews with forty-two women with physical disabilities, Frederick (2017) found WWD were subjected to being pathologized by unsupportive physicians. Frederick terms this phenomenon the "medical stare". WWD report being labeled as unfit mothers and unintelligent people due to their impairment. Frederick (2017) shared the story of a woman who experiences paralysis; the pediatrician who cares for the woman's daughter reported her to child services for being an incompetent parent, even though the physician had no basis for this claim (Frederick 2017). This woman and others in Frederick's study report being surveilled by physicians when at medical visits (Frederick 2017). The medical surveillance experienced by mothers with disabilities differs from surveillance experienced by able-bodied mothers because WWD are surveilled when they are patients as well as when their children are patients. Since WWD are assumed to be "risky" mothers, healthcare providers have a preconceived notion that mothers with disabilities need to be surveilled; this is not necessarily true of able-bodied women (Prilleltensky 2004; Thomas 1997).

A medical perspective of disability deems impairments as bodily abnormalities that should be treated. The medical perspective views WWD who choose to have children as irresponsible because this model deems babies with impairments as "lesser" compared to able-bodied babies (Thomas 1997; Frederick 2017). Some WWD are socialized to the notion that they should not become mothers (or simply do not wish to become mothers) and have ambivalent

feelings toward children (Prilleltensky 2004; LaPierre et al. 2017). In contrast, WWD who desire children often face the unsupportive attitudes of healthcare providers, weigh the risk of passing impairments to future children if their impairments are inheritable, and negotiate barriers to reproductive healthcare (LaPierre et al. 2017; Prilleltensky 2004; Frederick 2017).

When WWD are misrepresented as asexual and unfavorable mothers, not only do they not receive important information about sexual health, but they also experience difficulty attaining adequate reproductive healthcare (Bernert 2011; McRee, Haydon, and Halpern 2010 2010; Vaughn et al. 2015). Such disparities in reproductive healthcare can negatively impact WWD's ability to have children and seek fertility resources when needed (Vaughn et al. 2015). Existing studies investigating the relationship between disability, pregnancy, and motherhood use qualitative data that may not be generalizable to the broader population of WWD in the United States. Additionally, no existing studies use recent survey data to examine the relationship between disability and utilization of fertility services; without such studies, scholars cannot investigate if disparities in accessing adequate reproductive healthcare effects WWD's utilization of fertility services.

PREGNANCY, ABORTION, AND REPRODUCTIVE HEALTHCARE BARRIERS

Individuals with disabilities engage in sexual behaviors, and thus, have reproductive health needs, much like their able-bodied peers (McRee et al. 2010; Vaughn et al. 2015). However, individuals who have disabilities face barriers to reproductive health information and services (Horner-Johnson et al. 2016). WWD are significantly more likely to be advised by healthcare providers to never get pregnant compared to able-bodied women (Wu et al. 2017; Becker et al. 1997). Qualitative scholarship corroborates this finding; LaPierre and colleagues (2017) reported respondents struggled to find healthcare providers who were supportive and understanding of

their pregnancy desires. Another study found nine out of ten women with disabilities had negative experiences discussing pregnancy with their obstetricians (Vaughn et al. 2015). While WWD have difficulty accessing reproductive healthcare services due to structural barriers, such as inaccessible medical equipment and intake forms, WWD state their biggest barrier is caused by healthcare providers who are unknowledgeable about WWD's reproductive healthcare needs or unsupportive of their reproductive health desires (Becker et al. 1997; Lawler, Lalor, and Begley 2013).

WWD face different barriers to attaining pregnancy compared to able-bodied women. Negative experiences with healthcare providers can limit WWD's access to motherhood because physicians act as gatekeepers by deciding what information and options about pregnancy they discuss or withhold from patients (LaPierre et al. 2017). In cases in which WWD were willing to risk negative outcomes for themselves, such as not taking or reducing medications, in order to decrease risks of pregnancy complications, physicians varied in how willing they were to encourage alternative treatments for WWD; some physicians go so far as to withhold information and access to fertility treatments from WWD (LaPierre et al. 2017; Thomas 1997; Mitchelson 2009; Mosher et al. 2017). While scholars have documented physicians' unwillingness to share information about fertility services there is a dearth of scholarship about WWD's utilization of these services; this study aims to add to this literature by contributing knowledge about WWD's utilization of fertility services.

While WWD face many obstacles to becoming pregnant, quantitative literature finds WWD experience pregnancy at similar rates compared to able-bodied women (Horner-Johnson et al. 2016). Horner- Johnson et al.'s study uses data from the 2008-2012 Medical Expenditure Panel Survey, which is nationally representative, the study only examines women who reported a

pregnancy during the year they were interviewed. Other literature indicates WWD are less likely to have children compared to able-bodied women (Graham 1993). These findings beg the question: What happens between conception and when childbirth should occur? Since the twentieth-century eugenics movement disability has been viewed as an undesirable condition that can be eliminated by controlling the reproduction of WWD (Carey 2009; Flavin 2009). Just as women are labeled as “good” or “risky” mothers, fetuses are also assigned “good” and “bad” labels (Ettore 2009). Regardless of whether a woman’s disability is hereditary or not, WWD are labeled as “risky” mothers who are assumed to conceive “bad” (read disabled) fetuses (Frederick 2017; Thomas 1997). Thus, some healthcare providers seek to control WWD’s reproductive abilities by suggesting WWD be sterilized before have any (more) children (Thomas 1997). Other WWD are encouraged by healthcare providers to abort pregnancies when they conceive (Frederick 2017). Through these gatekeeping actions, healthcare providers limit WWD access to biological motherhood by devaluing babies who might have impairments. While literature finds some physicians encourage WWD to abort their pregnancies, there is a dearth of research that quantitatively examines the relationship between disability and receiving an abortion; this study aims to fill that gap.

Whether or not women have a disability or not does not account totally account for their attitudes about motherhood, experiences with pregnancy and abortion, and utilization of fertility services. Other factors that may explain this association include biological limitations of WWD’s impairments (LaPierre et al. 2017), educational attainment, and access to financial resources and insurance (Bloom et al. 2017; Shandra et al. 2014). Existing literature has found women who are more educated and have higher incomes have fewer children and have them later in life (Briggs 2017; Meyer and Mok 2018). Accounting for health insurance is important because it is an

indicator of socioeconomic status and other aspects of individual's social location which might affect their decision to become pregnant (Horner-Johnson et al. 2014). It is particularly pertinent to control for health insurance when studying WWD because some literature indicates found persons with cognitive disabilities had significantly less access to health insurance than other groups of persons with physical disabilities and no disabilities (Horner-Johnson et al. 2014).

HYPOTHESES

Most studies examining individuals with disabilities' experiences obtaining reproductive health information and healthcare have used qualitative methods. While demographic studies of health disparities experienced by WWD exist, the majority of studies analyzing reproductive health issues are qualitative. Currently, few studies quantitatively analyze WWD's experiences with attaining motherhood. In this study I will examine WWD's and able-bodied women's attitudes about motherhood, experiences with pregnancy and abortion, and utilization of fertility services. This study aims to add to the motherhood and disability literature by examining these relationships with nationally representative data, from which results can be generalized to the broader population of women in the United States. I pose four research questions: 1. Do WWD have different attitudes about motherhood compared to able-bodied women? 2. Are WWD less likely to experience pregnancy compared to able-bodied women? 3. Are WWD more likely to receive an abortion compared to able-bodied women? 4. Are WWD less likely to utilize fertility services?

Previous studies have concluded WWD have been shown to have similar attitudes about and desires for motherhood compared to able-bodied women (Bloom et al. 2017; Shandra et al. 2014). However, WWD experience unsupportive attitudes from parents and physicians about becoming mothers, in addition to receiving inadequate information about sex and reproductive

health (Prilleltensky 2004; Thomas 1997; Frederick 2017 Wu et al. 2017; Becker et al. 1997). Thus, I hypothesize WWD will be less likely to value motherhood compared to able-bodied women (*Hypothesis 1*).

Existing scholarship illuminates a lengthy history of WWD being excluded from motherhood (Thomas 1997; Frederick 2017; Prilleltensky 2004; Flavin 2009). WWD receive messages from parents and healthcare providers that they are unfit to be mothers and will have a difficult time attaining partners with which to have children (Prilleltensky 2004). Additionally, WWD are significantly more likely than able-bodied women to be advised by physicians to never become pregnant (Wu et al. 2017). However, WWD are often assumed to be asexual and thus receive inadequate sex education and information about reproductive healthcare (Wu et al. 2017; Becker et al. 1997) Based on this literature, I expect WWD to be less likely to have ever been pregnant compared to able-bodied women (*Hypothesis 2*). Building off the notion that WWD do not receive adequate sex education or reproductive healthcare and society tends to devalue babies born with impairments, I further hypothesize that WWD be more likely to have ever had an abortion compared to able-bodied women (*Hypothesis 3*).

Current literature posits healthcare providers act as gatekeepers to information and resources about pregnancy (LaPierre et al. 2017; Mosher et al. 2017). When physicians are unsupportive of WWD's desires for motherhood and withhold information about pregnancy they limit the reproductive healthcare services available to WWD (Becker et al. 1997; Lawler et al. 2013). Expanding upon this literature, I hypothesize WWD will utilize fertility assistance less than able-bodied women (*Hypothesis 4*).

METHODS

Data

To examine the effect of disability on motherhood, pregnancy, and abortion, I use data from the National Survey of Family Growth (NSFG). The NSFG is a multi-stage probability-based nationally representative survey of men and women ages fifteen to forty-four, which was designed and conducted by the National Center for Health Statistics. Data was collected through in-person interviews. Individuals who are institutionalized, incarcerated, or in the military during the time of data collection were excluded from the sample. The NSFG was conducted to yield national estimates of factors affecting pregnancy, reproductive healthcare involving contraception, infertility, and childbirth, factors affecting marriage and families, adoption, use of reproductive healthcare, and attitudes about childbearing, sex, and marriage. For the purposes of this study, the sample was restricted to women. Data from 2011 to 2013, 2013 to 2015, and 2015 to 2017 were combined to create a sample with data spanning six years. The initial 2011- 2017 NSFG data set contained 33,045 respondents. After dropping cases that were missing on disability measures (number of cases dropped=16,204), missing the importance of having children item (number of cases dropped=5,565), and who were over the age of 44 (number of cases dropped=3) (the 2015-2017 wave only included women 15 to 50) the sample size became 11,285 cases. Models 3 further excluded women who had not been pregnant, giving this model a smaller sample size (n= 6,963).

Key Independent Variable: Disability

The NSFG uses the six items developed by the IFC to measure disability. Participants were asked the following questions:

1. “Do you have serious difficulty hearing?”
2. “Do you have serious difficulty seeing, even when wearing glasses or contact lenses?”
3. “Because of a physical, mental, or emotional conditions, do you have serious difficulty concentrating, remembering, or making decisions?”
4. “Do you have serious difficulty walking or climbing stairs?”
5. “Do you have difficulty dressing or bathing?”
6. “Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone, such as visiting a doctor’s office or shopping?”

Answers to these six items were dichotomously coded by the NSFG. I combined these items into a single item measuring disability; a participant who answered yes to any of the six IFC questions was coded as having a disability (Bloom et al. 2017; Mosher et al. 2017; Mosher et al. 2018).

Dependent Variables

Attitudes about motherhood are measured by the item, “People can’t really be happy unless they have children.” Answers are coded on a five-point Likert scale, with one being strongly disagree and five being strongly agree.

The NSFG asking respondents to report the number of times they have ever been pregnant and the number of times they have ever had an abortion. For the purposes of my analyses, I recoded each of these variables into dichotomous variables to indicate if they have ever had a pregnancy (1=yes, 0=no) or an abortion (1=yes, 0= no).

The NSFG measures access to reproductive healthcare and fertility services by asking respondents to report all the medical help they have ever received to help them become pregnant. Respondents were given the following choices: advice from a physician, infertility testing, drugs to improve ovulation, surgery to correct blocked tubes, artificial insemination, or other types of medical health. To examine women's access to fertility assistance, this variable was recoded so that a participant who utilized any of the listed services were considered to have accessed services.

Control Variables

Race, years of education, age, income, and type of insurance are used as control variables. Race was ascertained by asking participants what race they consider themselves to be. Responses were then recoded by the NSFG into the following categories: Black, White, and other; White is used as the reference group in all models. Participant's educational attainment was measured by asking individuals what the highest grade/degree was they had completed at the time of the interview. This variable was recoded into some high school, high school or GED; some college/no bachelor's degree; Bachelor's degree or higher (Wu et al. 2017); some high school is used as the reference group. Participant's reported their current insurance type under four categories: private insurance or Medi-Gap; Medicaid, CHIP, or a state-sponsored health plan; Medicare, military health care, or other government health care; or uninsured. This variable was collapsed into three categories: private insurance, government insurance, or no insurance (Mosher et al. 2018); private insurance is used as the reference group in all models.

Income was coded into fifteen categories (categories are reported using midpoints): \$2,502/year; \$5,246/year; \$8,742/year; \$11,244/year; \$13,746/year; \$17,496/year; \$22,494/year; \$27,492/year; \$32,496/year; \$37,494/year; \$44,994/year; \$54,996/year; \$67,494/year;

\$87,492/year; \$100,000. The lowest income category was used as the reference group. Participants who did not answer this question were asked a series of follow up questions to estimate their yearly income (Was it less than \$35,000? Was it less than or more than \$50,000?). Individuals who did not answer the income question but answered the follow-up questions were placed in the appropriate income category. For example, an individual who reported their income was more than \$35,000 but less than \$50,000 was placed in the \$44,994/year category. Data for individuals who did not answer any income questions were imputed³ into the mean category, which was the \$32,496/year category.

Analysis

To investigate the relationship between having a disability and attitudes about the importance of children (Model 1) an ordered logistic regression was conducted. An ordered logistic regression was selected because the dependent variable is coded on a five-point Likert scale (Long and Freese 2006).

To examine the relationship between having a disability and ever having been pregnant (Model 2), the relationship between being disabled and having ever had an abortion (Model 3), and the effect of disability on utilization of fertility services (Model 4), binary logistic regressions were administered. Binary logistic regressions were chosen due to the dichotomous nature of the dependent variables (Long and Freese 2006). The data used in Models 2, 3, and 4 have no outliers or multicollinearity, an adequate sample size ($n > 6,000$) and includes more than two continuous and/or categorical predictor variables; thus, all the regression's assumptions are satisfied (Long and Freese 2006).

RESULTS

Table 1 provides demographic information about respondents. Respondents are predominately white (65.1%), able-bodied (79.8%), and 25- 34 years of age (36.6%). Most respondents had completed a bachelor's degree (28.3%) and had an annual income of \$20,000 and \$39,999 (30.6%). About twenty percent of respondents reported having some type of disability. Respondents who reported having a disability, on average, had lower educational attainment and yearly income compared to able-bodied women.

Table 1. Respondent Descriptive Statistics and Bivariate Analyses by Disability Status

	Total Sample (N=11,273)	Women with Disabilities (N=2,280)	Able-bodied Women (N=8,993)	P-Values
Race*				0.02
% White	65.1	63.2	65.5	
% Black	23.2	25.4	22.6	
% Other	11.8	11.4	11.9	
Age***				p< 0.01
% 15-24	35.1	38.9	34.1	
% 25-34	36.6	32.6	37.6	
% 35-44	28.4	28.4	28.3	
Educational Attainment***				p< 0.01
Some high school	11.8	16.7	10.6	
High school diploma/GED	14.1	20.1	12.6	
Some college	22.5	26.8	21.4	
Bachelor's degree	28.3	26.4	28.8	
Graduate degree	23.3	10.0	4.5	
Insurance***				p< 0.01
Private	19.5	21.6	18.9	
Medicaid	25.0	37.5	21.8	
Medicare, military	5.0	7.6	4.4	

<i>insurance, or other government insurance</i>	50.5	33.3	54.9	
<i>Uninsured</i>				p< 0.01
Annual Income***				
<i>under \$20,000</i>	29.9	43.1	26.6	
<i>\$20,000 - \$39,999</i>	30.6	32.6	30.4	
<i>\$40,000 - \$59,999</i>	14.0	10.9	14.6	
<i>\$60,000 - \$74,999</i>	7.5	4.7	8.2	
<i>\$75,000 - 99,999</i>	6.5	3.4	7.2	
<i>\$100,000 or above</i>	11.6	6.5	12.9	
Importance of having children				0.094
<i>Strongly Agree</i>	0.42	0.57	0.38	
<i>Agree</i>	49.3	47.6	49.7	
<i>Neither agree nor disagree</i>	1.8	2.1	1.7	
<i>Disagree</i>	42.9	43.4	42.8	
<i>Strongly Disagree</i>	5.6	6.4	5.4	
Utilized fertility services				0.45
<i>Yes</i>	7.1	6.7	7.2	
<i>No</i>	92.9	93.3	92.8	
Ever been pregnant				0.37
<i>Yes</i>	38.2	62.6	61.6	
<i>No</i>	61.8	37.4	38.4	
Ever had an abortion				0.30
<i>Yes</i>	51.7	52.7	51.5	
<i>No</i>	48.3	47.3	48.5	

Note: * p < 0.05; ** p < 0.01; *** p < 0.001

Table 2 presents the findings from the order logistic regression, Model 1a, which examines how having a disability is related to women's views about the importance of having children. The Prob > Chi² value of 0.00 indicates having a disability is a significant predictor of attitudes about the importance of having children. Net of other variables disability, age, education, race, annual income were found to be significantly related to women's attitudes about the importance of having children. Compared to white women, Black women were less likely to value having children, net of other variables ($p<0.01$). Additionally, women of other races had decreased odds (log odds= 0.71) of viewing having children as necessary to happiness compared to White women. The odds of WWD viewing having children as unimportant is 0.15 times that of able-bodied women, when controlling for age, race, income, and insurance. Additionally, women who are older, more educated, and have higher incomes are less likely to value having children. Insurance was not related to women's attitudes about the importance of children.

Table 2. Model 1: Disability and the Importance of Children

	Model 1a	Model 1b
Disability	1.02 (0.07)	0.86* (0.07)
Age		1.02*** (0.00)
Insurance		0.97(0.02)
Education		0.83*** (0.02)
Race		
<i>Black</i>		0.79*** (0.07)
<i>Other</i>		2.04*** (0.09)
Annual Income		0.97*** (0.01)
Observations	11,273	11,273
Pseudo R ²	0.00	0.021

Note: Standard errors in parentheses

Coefficients reported are odds ratios

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

Table 3 outlines the findings of the binary logistic regression used to examine the effect of having a disability on women's utilization of fertility services. The Prob > Chi² value of 0.00

indicates Model 4 significantly predicts women's utilization of fertility services. Age, insurance, education, annual income, and primarily infertility are significant predictors of using fertility services. Net of other variables, women in higher income categories had increased odds (OR=1.06) for fertility service utilization compared to women in the lowest income category. After controlling for age, insurance, education and income, Black women had decreased odds of utilizing fertility services (OR=0.52) compared to White women. Disability is not a significant predictor of fertility service utilization ($p=0.15$).

Table 3. Model 2: Disability and Utilization of Fertility Services

	Model 2a	Model 2b	Model 2c
Disability	0.86 (0.12)	1.23 (0.18)	1.23 (0.18)
Age		1.08*** (0.01)	1.08*** (0.01)
Insurance		1.21*** (0.06)	1.22*** (0.06)
Education		1.21*** (0.06)	1.21*** (0.06)
Race			
<i>Black</i>		0.52*** (0.09)	0.52*** (0.09)
<i>Other</i>		0.84 (0.15)	0.81 (0.15)
Annual Income		1.06*** (0.02)	1.06*** (0.02)
Importance of Children			1.08 (0.06)
Observations	11,273	11,273	11,273
Pseudo R ²	0.00	0.12	0.11

Note: Standard errors in parentheses

Coefficients reported are odds ratios

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

Table 4 presents the results of the binary logistic regression used to examine the relationship between having a disability and having had a pregnancy. The Prob > Chi² value of 0.00 indicates Models 2a, 2b, and 2c are significant predictors of the whether women have ever been pregnant. The model indicates that disability does is not a significant predictor of whether or not women get pregnant ($p= 0.99$), net of other variables; instead other factors such as age, race, annual income, insurance, and educational attainment influence pregnancy outcomes. Net

of other variables, women who have lower educational attainment and lower annual incomes are more likely to have had a pregnancy.

Table 4. Model 3: Disability and Pregnancy

	Model 2a	Model 2b	Model 2c
Disability	1.15 (0.08)	1.0 (0.08)	1.07 (0.09)
Age		1.24*** (0.01)	1.19*** (0.01)
Insurance		0.80*** (0.02)	0.77*** (0.03)
Education		0.71*** (0.02)	0.69*** (0.03)
Race			
<i>Black</i>		1.52*** (0.13)	2.05*** (0.18)
<i>Other</i>		0.84 (0.09)	0.84 (0.10)
Annual Income		0.96*** (0.01)	0.93*** (0.01)
Importance of Children			1.04 (0.04)
Constant	1.15*** (0.05)	0.03*** (0.01)	0.83 (0.23)
Observations	11,273	11,273	11,273
Pseudo R ²	0.00	0.32	0.37

Note: Standard errors in parentheses

Coefficients reported are odds ratios

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

Table 5 displays the results of the binary logistic regression used to examine the relationship between having a disability and having had an abortion. The sample for this model is further restricted to exclude women who had never been pregnant. The Prob > Chi² value of 0.00 indicates Model 3 is a significant predictor of whether women had ever received an abortion. After controlling for age, race, income, education, insurance, and importance of having children, the odds of WWD having an abortion is 1.52 times that of able-bodied women ($p < 0.01$). Age, insurance, education, marital status, annual income, and attitudes about the importance of children were also found to have a significant effect on whether or not women had ever received an abortion. Women who do not have private insurance are more likely to have had an abortion compared to women with private insurance. Women who have higher annual incomes are more

likely to have had an abortion compared to women in lower income categories. Lastly, women who score lower on the importance of having children are more likely to have had an abortion compared to women who report having children is important to being happy.

Table 5. Model 4: Disability and Abortion

	Model 2a	Model 2b	Model 2c
Disability	1.36** (0.15)	1.52*** (0.17)	1.49*** (0.17)
Age		0.99 (0.01)	0.99 (0.01)
Insurance		1.03 (0.04)	1.03 (0.04)
Education		1.13** (0.04)	1.12* (0.04)
Race			
<i>Black</i>		2.2*** (0.22)	2.12*** (0.21)
<i>Other</i>		0.95 (0.14)	1.01 (0.15)
Annual Income		1.01 (0.01)	1.01 (0.01)
Importance of Children			0.84*** (0.04)
Constant	0.24*** (0.01)	0.16*** (0.04)	0.27*** (0.07)
Observations	6,963	6,963	6,963
Pseudo R ²	0.00	0.00	0.00

Note: Standard errors in parentheses

Coefficients reported are odds ratios

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

DISCUSSION

A wealth of literature documents the stigma and social inequalities faced by PWD (McRuer 2006; Mollow and McRuer 2006; Hall 2011). One such aspect of life in which WWD face stigma and discrimination is in attaining motherhood. Existing literature finds WWD receive societal messages that they will struggle to find partners and become competent parents; parents and healthcare providers discourage WWD from having children (Prilleltensky 2004; Becker et al. 1997; Lawler et al. 2013, Vaughn et al. 2015). According to some researchers (Horner-Johnson et al. 2016; Shandra et al. 2014) WWD are found to have similar desires for motherhood and rates of pregnancy compared to able-bodied women. Other research finds

WWD are less likely to be mothers compared to able-bodied women (Graham 1993). This study sought to reconcile these discordant findings. I addressed four research questions: 1. Do WWD have different attitudes about motherhood compared to able-bodied women? 2. Are WWD less likely to experience pregnancy compared to able-bodied women? 3. Are WWD more likely to receive an abortion compared to able-bodied women? 4. Are WWD less likely to utilize fertility services?

Results from **Model 1** indicate WWD have decreased odds of agreeing with the notion that having children is necessary for happiness compared to able-bodied women. This finding supports *Hypothesis 1*, which anticipated WWD would place less value on having children compared to able-bodied women. This finding is discordant with existing literature which finds WWD have similar desires for motherhood as able-bodied women (Shandra et al. 2014). I posit results from Model 1 highlight the effects of societal attitudes about WWD being unfit mothers. Many scholars detail WWD's stories of being excluded from rites of "normal" womanhood, such as being sexually active and having children. Societal stereotypes construct PWD as being childlike and asexual (Lofgren-Martenson 2013; Mollow and McRuer 2006). Additionally, notions of compulsory able-bodiedness deem impaired bodies deviant, unattractive, and undesirable (McRuer 2006). PWD grow-up receiving messages that they will not engage in sex and are undesirable sexual partners. Likewise, WWD are told by parents and physicians that they are unfit to be mothers and are discouraged from getting pregnant (Prilleltensky 2004; Frederick 2017; LaPierre et al. 2017; Wu et al. 2017). As a result, some WWD become socialized to societal notions of "normal" and "acceptable" motherhood and root their identities as women in activities and roles other than motherhood, placing less emphasis on motherhood for them.

Results from Model 2 indicates that having a disability does not significant predict an individual's utilization of fertility services; thus, support was not found for *Hypothesis 4*, which stated that WWD would utilize fertility assistance less than able-bodied women. This result contradicts findings of existing literature, which reports healthcare providers often withhold information about services to aid in conception from WWD and other marginalized groups (LaPierre et al. 2017; Kissil and Davey 2012; Mitcherson 2009).

My results do not find a significant relationship between disability and pregnancy. This finding does not support *Hypothesis 2*, which posited WWD would be more likely have ever had a pregnancy compared to able-bodied women. While this model did not test rates of pregnancy like existing studies, it does align with current literature's conclusion that WWD and able-bodied women are equally likely to experience pregnancy (Horner-Johnson et al. 2016). Results from Model 3 indicate other factors, such as educational attainment and annual income, are more accurate predictors of pregnancy. Existing literature has established educational attainment and income have a negative relationship with pregnancy; as women earn more income and become more educated they have fewer children (Briggs 2017). Literature has also established a link between educational attainment and disability (Meyer and Mok 2018).

Consistent with *Hypothesis 3*, findings from Model 4 suggest WWD are more likely to have an abortion compared to able-bodied women. This finding supports *Hypothesis 3* and provides an important contribution to the body of motherhood and disability literature by illuminating the relationship between having a disability and abortion. Existing literature provides narratives of WWD being encouraged by healthcare providers to terminate fetuses, no study has quantitively investigated the likelihood of WWD to have an abortion compared to able-bodied women. A possible explanation of WWD's increased odds of having abortions compared

to able-bodied women is a manifestation of ableist and eugenic ideologies in medical institutions. Since the eugenic movement of the twentieth century, disability has been viewed as a medical issue that should be eradicated (Carey 2009; Flavin 2009). Since this time, in conjunction with increased availability of genetic testing, it has become common practice for physicians to screen fetuses for genetic anomalies and counsel mothers- able-bodied women and WWD alike- to terminate fetuses who are at risk of being born with an impairment (Frederick 2017). WWD are labeled as “risky” mothers who are likely to have children with impairments, even when WWD’s impairments are not hereditary (Frederick 2017; Thomas 1997). In an attempt to control WWD’s reproduction and minimize the number of babies born with impairments, some physicians encourage WWD to abort pregnancies (Frederick 2017).

Limitations

Although this study makes an important contribution to the literature on disability and motherhood, it is not without limitations. The NSFG’s use of the IFC definition disability provides a crude measure of disability that overlooks the differences between types of impairments (cognitive versus physical versus developmental) and severity of impairments; in using this measure nuances in the impairment-specific experiences of women are silenced. This study could use impairment-specific categories of disability because there were not enough women in each category. Additionally, the NSFG only inquires about disability at the time of interview and does not provide a complete picture of disability overtime in women’s lives, particularly at the time mothers gave birth; as a result, the NSFG does not capture women who acquired disabilities after having children. Future studies should strive to measure disability in a way that more adequately captures the variety of impairments and experiences women encounter, by inquiring about when disabilities were acquired. Lastly, this study did not include

marital status in the analyses, which some studies argue is an important predictor of women's pregnancy intentions (Zimmerman 1977). Future studies should include measures of marital status in analyses (see Appendix A).

CONCLUSION

Results from this study present a nuanced examination of the relationship between disability and attitudes about motherhood, pregnancy, and abortion. The findings presented in this study highlight the influence of compulsory able-bodiedness on WWD experiences with motherhood, pregnancy, and abortion. WWD place less emphasis on having children compared to able-bodied women. I argue this is due to WWD being socialized to accepted hegemonic ideas about motherhood. Using a nationally representative sample, my results indicated no difference in between WWD's and able-bodied women's likelihood of experiencing pregnancy and their utilization of fertility services. In addition to contributing an updated and generalizable analysis of pregnancy and attitudes about motherhood among WWD with recent data, this study builds on the existing disability and motherhood literature by quantitatively examining how having a disability is related to women's likelihood of ever having had an abortion. WWD's increased likelihood of ever having had an abortion points to inadequate access to contraceptive and eugenic ideas about impairments being embedded in the institution of medicine.

More research is needed to investigate the relationship between pregnancy and disability, and fertility services utilization and disability. Research should examine the relationship between having a disability on factors that strongly influence pregnancy rates and healthcare utilization, such as educational attainment, income, and insurance. Lastly, researchers should collect data which include more WWD compared to existing data sets so the effects of different types of impairments can be analyzed.

Endnotes

1. For the purposes of this study, I have chosen to use person first language. Feminist disability studies highlights the importance of person first language; feminist scholars believe person first language does not reduce people to a particular characteristic of their identities (Garland-Thomas 2005). Feminist disability scholars believe it is important to consider how persons relate to labels assigned to them; for example, in place of “women with disability”, it is preferable to say, “women who identify as disabled” (Garland-Thomas 2005). Using the latter type of language was not an option for my study because the NSFG does not ask women how they identify with the labels “disabled” and “impaired”.
2. Feminist Disability Studies aims to reclaim the identities of “woman” and “disabled” from their normative conceptions (Hall 2011; Garland-Thomson 2005). Historically the social category of “woman” has been defined in relation to “man”; similarly, “disabled” is defined in relation to “able-bodied” (Hall 2011). Based on notions that women are seen as being lesser than men, some feminists have suggested the social category of “woman” can be understood as a type of physical disability (Hall 2011; Young 2005). Feminist disability scholars posit this conception of “woman” as a disability underscores the experiences of PWD, specifically WWD (Hall 2011).
3. For the purposes for this study, I imputed missing data into the mean category. While this is not the most sophisticated or accurate method of imputation, its use is acceptable. More sophisticated techniques, such as multiple imputation were not used due to time constraints. It was important to impute cases in which income was missing because the missing cases were found to be significantly correlated to having a disability. Any method of imputation introduces bias into an analysis; in this case, the bias introduced into the analysis by using imputation was

deemed necessary compared to the bias that would have been introduced if the missing cases were dropped.

Appendix A

Models including Marital Status

Model 1.2. Disability and the Importance of Children

Model 1.2	
Disability	0.87 (0.072)
Age	1.01* (0.004)
Insurance	0.97 (0.025)
Education	0.83*** (0.024)
Race	
<i>Black</i>	0.83* (0.067)
<i>Other</i>	2.06*** (0.086)
Annual Income	0.96*** (0.007)
Marital Status	0.92*** (0.018)
Observations	11,273
Pseudo R-Squared	0.0231

Note: Standard errors in parentheses

Coefficients reported are odds ratios

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

Model 2.2. Disability and Utilization of Fertility Services

Model 2.2	
Disability	1.32 (0.120)
Age	1.06*** (0.009)
Insurance	1.19** (0.063)
Education	1.23*** (0.067)
Race	
<i>Black</i>	0.65* (0.112)
<i>Other</i>	0.82 (0.147)
Annual Income	1.01 (0.017)
Importance of Children	1.04 (0.055)
Marital Status	3.79*** (0.512)
Observations	11,273
Pseudo R-Squared	0.146

Note: Standard errors in parentheses

Coefficients reported are odds ratios

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

Model 3.2. Disability and Pregnancy

Model 3.2	
Disability	1.08 (0.095)
Age	1.21*** (0.009)
Insurance	0.77*** (0.026)
Education	0.69*** (0.026)
Race	
<i>Black</i>	1.9*** (0.168)
<i>Other</i>	0.82 (0.098)
Annual Income	0.93*** (0.009)
Importance of Children	1.04 (0.035)
Marital Status	4.66*** (0.464)
Observations	11,273
Pseudo R-Squared	0.361

Note: Standard errors in parentheses

Coefficients reported are odds ratios

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

Model 4.2. Disability and Abortion

Model 4.2	
Disability	1.42* (0.163)
Age	0.2 (0.007)
Insurance	1.07 (0.047)
Education	1.13* (0.046)
Race	
<i>Black</i>	1.82*** (0.191)
<i>Other</i>	1.01 (0.15)
Annual Income	1.05*** (0.014)
Importance of Children	0.87** (0.04)
Marital Status	0.38*** (0.043)
Observations	6,963
Pseudo R-Squared	0.056

Note: Standard errors in parentheses

Coefficients reported are odds ratios

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

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