societies

Review

Disabling Norms, Affirming Desires: A Scoping Review on Disabled Women's Sexual Practices

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Abstract: Disabled women have historically been marginalized from sexuality education and discussions due to harmful stereotypes that portray them as asexual or incompatible with cis-heteroreproductive sexual norms. To assess whether these assumptions are supported by empirical evidence, a scoping review was conducted following Arksey and O'Malley's proposal and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for scoping reviews (PRISMA-ScR). The protocol is registered with the Open Science Framework. EBSCOhost, SCOPUS, and Web of Science databases were searched to map peer-reviewed scientific articles published between 2013 and 2023 on disabled women's sexual practices. Seven qualitative studies were selected and analyzed through reflexive thematic analysis. Four key themes were identified: Reclaiming Sexuality, Navigating Constraints, Barriers to Awareness, and Building Inclusive Futures. The findings illustrate the diversity of sexual experiences among disabled women and highlight their active role in overcoming the barriers imposed by their bodies and environments. This review contributes to a broader discourse on sexuality and disability, challenges oversimplified narratives of de-sexualization, and provides evidence supporting a paradigm shift towards inclusive, affirmative sexual health education. Further research and policy reforms are essential to ensure recognition of their sexual citizenship, desires, and lived realities.

Keywords: sexuality; disability; disabled women; sexual citizenship; intersectionality; scoping review

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1. Introduction

The World Health Organization [1] defines sexuality as a central aspect of the human experience, encompassing sex, gender (identity and roles), sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is a multifaceted phenomenon expressed through thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles, and relationships. Given its critical relevance to psychological and overall well-being, sexual needs and their expression are increasingly recognized as a basic human need and a vital component of health. Accordingly, sexual health concerns the state of physical, mental, and social well-being regarding a person's own sexuality [1].

The experience of sexuality is influenced by the dynamic between an individual and their broader context, shaped by the intricate interplay of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious, and spiritual factors [1]. Achieving sexual health and fulfillment, therefore, requires fostering favorable conditions across these dimensions through a positive and respectful approach to sexuality, ensuring the sexual and reproductive rights of all people, regardless of their social status or physical and mental abilities [1].

Sexual and reproductive rights, while not formally recognized as fundamental human rights, pertain to sexuality and human dignity [1,2]. Although these are not explicit in the Universal Declaration of Human Rights, organizations such as the International Planned Parenthood Federation [3] and the World Association for Sexual Health [4] advocate for their recognition and have issued declarations asserting these rights.

Despite some nuances, these declarations collectively emphasize the rights to equality and non-discrimination; to life, safety, and freedom from violence and coercion; to bodily autonomy and integrity; to privacy; to freedom of thought, opinion, and expression; to access to comprehensive sexual education and quality sexual healthcare services; to benefit from scientific advancements; to choose to be sexually active or abstinent; to marriage freedom; to decide whether and when to have children; and to pursue a satisfying sexual life [1–4]. To uphold and promote sexual citizenship[1], many countries have integrated these concerns into their policies and legislations, particularly measures of sexual education, family planning, abortion, and equitable access to marriage [2]. Despite several Western nations removing legal barriers, societal attitudes, stereotypes, and entrenched social prejudices continue to obstruct the full realization of these rights [2,7,8].

The scarcity of specialized knowledge, resources, and technical training addressing the sexuality of disabled women and its impact on this group's sexual health have been documented, e.g., [7,9,10]. However, the lack of sex education extends beyond professional healthcare figures. Overprotective family members, caregivers, and educational agents believe discussing sexuality with this group is unnecessary and even inappropriate [7,11]. On the one hand, sex is socially framed as dangerous, perversive, heteronormative, and oriented towards coitus and procreation [12,13]. On the other, disabled people are perceived as childlike, innocent, vulnerable, and celibate [11,14]. Additionally, they may present intellectual differences that call into question their ability to consent, or motor restrictions that make certain sexual practices unfeasible, such as penetrative sex [7,10,11,14].

The taboo and silence surrounding eroticism are especially pronounced for disabled women, who face dual oppression within an ableist and sexist society [10,15,16]. Gender stereotypes impose expectations of reservation and conservatism in women's attitudes towards sexuality, which reinforce the misconception that disabled women are inherently asexual [10]. For non-heterosexual disabled women, limited awareness and education about queer identities further exacerbate the invisibility of their sexuality [7]. When they express their minority sexual identities, they are often invalidated, dismissed as symptoms of intellectual disability, understood as coping mechanisms for male rejection, or problematized due to homophobic social attitudes and prejudices [17,18].

The absence of comprehensive and inclusive sex education exacerbates these challenges. Formal sex education programs often prioritize heterosexual and penetrative practices [9,13], and available services and resources are typically segregated, addressing either disability or queer issues [19]. This sociosexual isolation perpetuates a cycle of social ignorance and the internalization of stigmas [7,9,10,13,19]. Consequently, disabled women typically feel ill-equipped to navigate sexuality [13] since they do not receive the necessary training to make informed decisions concerning the prevention of sexually transmitted infections or unwanted pregnancies, to identify sexual abuse, and to discover the sexual activities that best suit their personal characteristics [7,9,10,13]. However, this lack of understanding of their own sexuality often justifies abusive medical interventions, such as forced sterilizations and abortions [7].

The persistent belief that disabled women either lack sexuality or possess a radically different and atypical sexuality compared to the general population underpins their systematic exclusion from discussions on sexuality. Existing literature reviews indicate that research on disabled women's sexuality has largely followed risk-oriented and protective frameworks, disproportionately focusing on sexual violence, sexually transmitted infections, contraception, stigma, access to services, and other structural and interpersonal challenges, e.g., [20–22]. While these are relevant concerns, this emphasis has contributed to a narrow understanding of disabled women's sexual lives, neglecting positive experiences and how they adapt sexual practices to suit their bodies, needs, and contexts, to promote comfort, intimacy, and pleasurable sex. These gaps reinforce the dominant narratives that frame disabled women primarily as vulnerable.

In response, this scoping review aims to map and examine the scientific data on the sexual practices of disabled women in order to assess the validity of these assumptions. Guided by the Population/Concept/Context (PCC) framework [23], this review addresses the research question "How are disabled women's (=Population) sexual practices (=Concept) portrayed in the scientific literature (=Context)?". The object of study comprises empirical research of any design published in peer-reviewed and indexed scientific journals between 1 January 2013 and 31 December 2023 that explore the sexual practices of disabled women.

2. Methods

2.1. Study Design

In line with the study's aims, a scoping review approach was selected, as it enables mapping and exploring the research activity within a given field, supports the identification of gaps or underexplored topics in the literature, and offers an accessible synthesis of complex or fragmented data, thereby facilitating the dissemination of findings to inform policy and practice stakeholders [24].

The review followed Arksey and O'Malley's [24] methodological proposal for scoping studies, which consists of five stages:

1. Identifying the research question;
2. Identifying relevant studies for the review;
3. Selecting studies to include in the analysis;
4. Charting the data extracted from each article;
5. Collating, summarizing, and reporting the results.

The process was further guided by the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) checklist [25] to ensure transparency and rigor at each step. The protocol of this scoping review is registered with the Open Science Framework (https://doi.org/10.17605/OSF.IO/E2DBV).

This study was grounded in a feminist, social constructionist, anti-positivist, and anti-essentialist epistemological perspective. Within this standpoint, sexuality, disability, and gender are not conceived as inherent or fixed characteristics, but rather as socially constructed attributes shaped by dominant discourses operating within specific historical and cultural contexts [26]. Rather than seeking to uncover an objective reality, the focus is placed on accessing individual interpretations and lived experiences, which are mediated through language, relationships, and the broader social environment. These social constructions produce social expectations around the traits, behaviors, and roles assigned to identities such as disability and gender, often resulting in the internalization of systems of marginalization [26]. An intersectional, non-pathologizing, and justice-oriented lens was also adopted, recognizing the interaction between disability and gender as interlocking systems of oppression that shape disabled women's unique lived experiences [26].

2.2. Inclusion Criteria

This review focused on indexed peer-reviewed scientific research publications that met the following criteria:

1. Explores the sexual practices of disabled women;
2. Includes cis-heterosexual and/or queer disabled women in the study sample;
3. Employed a quantitative, qualitative, or mixed-methods research design;
4. Published between 1 January 2013 and 31 December 2023;
5. Available in Portuguese, English, or Spanish.

The review excluded sources such as books, book chapters, literature reviews, scale validations, intervention program reports, demographic analyses, theoretical or analytical essays, commentaries, guidelines, editorials, and other forms of grey literature.

2.3. Search Strategy

Research records were retrieved from three academic databases: EBSCOhost, SCOPUS, and Web of Science. The search query, adjusted to the syntax and search functionalities of each platform, included the keywords "disabled women" OR "women with disabilities" OR "women with functional diversity"[2], together with "sex" OR "sexual activity" OR "sexual practices". These terms were applied to titles and abstracts to ensure that the selected studies specifically addressed the topic of interest. The date range was limited to articles published between 1 January 2013 and 31 December 2023, in order to focus on recent scientific research. Only studies available in Portuguese, English, or Spanish were considered, as these are the languages in which the reviewing authors are fluent, thereby ensuring an accurate and comprehensive understanding of the results.

2.4. Data Extraction and Analysis

To treat the data in the selected studies, a reflexive thematic analysis (RTA) was conducted [28]. This method aligns with feminist and social constructionist epistemology, in which knowledge and meaning are understood as socially produced and contextually situated [26,28]. When applying this procedure, the subjectivity and reflexivity of the researchers are fundamental, acknowledging their active role in finding and defining the themes [28]. Themes refer to the patterns of shared meaning across the collected data that address the research questions [28]. Instead of objectivity and neutrality, RTA recognizes that the researchers' personal attitudes, experiences, and theoretical assumptions inevitably shape their engagement with the data, valuing transparency [28]. The authors are based in Portugal, with a background in psychology and sociology, and identify as cisgender, non-disabled, white women, with feminist and sex-positive perspectives, and non-practicing Catholic upbringings. These disciplinary groundings, social positions, and identities informed the interpretations and knowledge produced.

Data were extracted from each study regarding:

- Author(s);
- Year of publication;
- Research aim(s);
- Participants;
- Context;
- Study design;
- Main findings.

The process followed the six-phase approach developed by Braun and Clarke [28]:

1. Becoming familiar with the data through the integral reading of the articles that served as a corpus for the analysis, while elaborating a list of initial ideas with possible meanings on the data and filling the data charting form;
2. Identifying all aspects of each article relevant to the research question, inclusively and exhaustively, and assigning them a code;
3. Aggregating codes with the same or related meanings into potential themes;

4. Reviewing and refining the initial themes to ensure compliance with the homogeneity and mutual exclusion criteria;
5. Naming and clearly defining the themes;
6. Producing the scoping review output for results dissemination.

Rather than aiming for coding consensus, this analysis was guided by collaborative reflexivity [28]. The first author performed the literature search and data charting, analyzed the collected data, and drafted the initial manuscript. As the supervision team, the second and third authors oversaw the entire process, providing guidance, feedback, and critical insights throughout all stages of the review.

3. Results and Discussion

The initial database search made available a total of 124 studies. After screening articles by title and abstract, 113 works that did not meet the inclusion criteria were excluded. These publications consisted of: (1) literature reviews, media content analyses on the sexuality of disabled women, validation of scales or intervention programs, analysis of demographic questionnaires, and theoretical or analytical essays; (2) discussions of ethical considerations in research involving disabled people, but did not address issues directly related to sexual experiences; (3) had only male participants or did not differentiate the gender of the participants, and (4) only integrated participants with health issues that might lead to disability or with invisible disabilities. The last exclusion criterion underlies the assumption that disabled individuals whose impairments are not visibly apparent are often socially perceived in ways similar to non-disabled people and, as a result, are less likely to experience early stigmatization, asexualization, and other social barriers to their erotic expression [9].

Eleven articles were collected across all databases. Based on the recommendation of a subject-matter expert, an additional research article [10] fitting the inclusion criteria was added to the scoping review. While the initial web search did not capture it, its findings directly address the purposes of this review. After removing duplicates, seven studies were eligible for integral reading and, finally, considered for the final analysis and discussion of findings. Figure 1. depicts the flow diagram that summarizes this process.

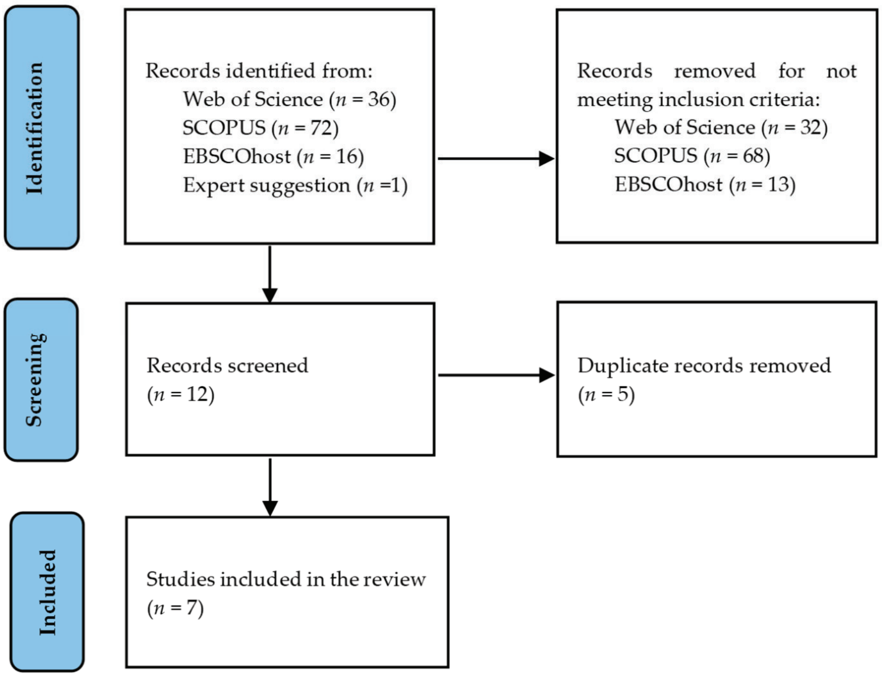

Figure 1. PRISMA 2020 flow diagram of identification of studies via databases [29].

The seven studies reviewed were published between 2015 and 2022. Two were conducted in Canada, one in Zimbabwe, another in New Zealand, and the remaining in different European countries, namely, the United Kingdom, Portugal, and Poland. All records included followed qualitative research methodologies. Further details on the characteristics of the studies analyzed can be found in Table 1.

Table 1. Tool for data extraction and systematization of the studies included.

Author(s)	Year	Objectives	Participants	Context	Study Design	Main Findings
Fish [30]	2016	Explore sexuality among intellectually disabled women living in a secure unit.	16 intellectually disabled women aged 18–60, and 10 staff members.	North England	Ethnographic, in-depth interviews, participant observation.	• Sexuality was highly regulated, limiting autonomy. • Abuse histories shaped women's sexual practices and relationships. • Staff framed women's desires as either promiscuity or vulnerability. • Despite restrictions, women resisted and sought intimacy. • Policies failed to balance protection with autonomy. Necessary reform for safe and consensual sexual expression.
Morales et al. [31]	2016	Document masturbation practices and sexual experiences of physically disabled men and women.	18 participants (10 men, 8 women); aged 18+; heterosexual and gay; physically disabled without cognitive impairments.	Quebec, Canada	Qualitative, semi-structured interviews, NVivo analysis.	• Women faced guilt linked to religion and societal pressures; men exhibited better anatomical knowledge. • Both men and women creatively adapt sex practices (e.g., making their own accessible sex toys). • Participants expressed the need for inclusive sex education and adapted sexual aids. • Masturbation seen as vital for physical and mental well-being but hindered by physical challenges and limited privacy.
Morales et al. [32]	2016	Explore disabled women's sexual experiences, perceptions of sexuality, and abuse.	8 heterosexual physically disabled women, aged 18+, without cognitive impairments.	Quebec, Canada	Qualitative, semi-structured interviews, NVivo analysis.	• Participants described sexuality as a sensual act and a right. • Many faced perceptions of asexuality, leading to silenced abuse experiences. • Religion and lack of sex education lead to guilt about sexual pleasure. • Role of masturbation in helping participants reconcile trauma but poses physical challenges. • Abuse was prevalent, influencing sexual attitudes and practices. • Need for prevention programs, education, and adapted sexual aids.
Payne et al. [33]	2016	Examine young physically disabled women's perspectives on sexuality and identity.	Four congenitally disabled women, aged 18–32, and three wheelchair users.	Auckland, New Zealand	Qualitative, participatory action research (PhotoVoice).	• Women expressed a desire to be seen beyond their disabilities. • Sexuality is perceived as more than physical acts, encompassing relationships and identity. • Societal stigma led to exclusion from beauty and intimacy norms. • Participants used self-representation (e.g., photography) to reclaim their sexual and personal identities. • Navigating intimacy involves confronting fear, rejection, and stigma. • Need to challenge asexuality myths and foster inclusive narratives of disabled sexuality.

Table 1. *Cont.*

Author(s)	Year	Objectives	Participants	Context	Study Design	Main Findings
Peta et al. [34]	2015	Explore how disability intersects with gender, cultural norms, and sexual experiences of women.	A 38-year-old Zimbabwean woman with polio, mother of two sons, HIV-positive.	Harare, Zimbabwe	Qualitative, biographical narrative interpretive method.	• Life trajectory marked by coercion and violence, leading to unwanted pregnancies and HIV. • Cultural stigma linked disability to spiritual evils, marginalizing disabled women. • Participant demonstrated resilience and entrepreneurship despite adversity. • Rejection by partners highlighted the gendered disparity in societal attitudes towards disabled women. • Need for empowerment and recognition of disabled women's agency.
Santos & Santos [10]	2018	Examine the social and cultural contexts of sexual experiences and desires of disabled women.	30 Portuguese white disabled women, aged 29–49, mostly heterosexual, non-practicing Catholics.	Portugal	Qualitative, feminist disability studies, biographical narrative	• Women experienced de-sexualization and infantilization by society. • Reclaimed sexuality through creative adaptations and exploration of non-genital erogenous zones. • Internet provides opportunities to bypass societal prejudices and barriers to intimacy. • Need for specialized professional training to address disabled women's sexual and reproductive rights and health. • Highlights the role of resilience and re-sexualization in resisting societal norms.
Wolowicz et al. [35]	2022	Investigate how non-heterosexual disabled women navigate care regimes and homophobia in institutional and non-institutional settings.	11 non-heterosexual congenitally physically disabled women, aged 30–47, mostly tertiary educated, with experiences in same-sex relationships.	Poland	Qualitative, Narrative analysis, NVivo, semi-structured interviews.	• Women faced infantilization and de-sexualization, compounded by homophobia. • Fear of rejection limited self-disclosure in relationships. • Resilience strategies include forming support networks and advocating for recognition. • Healthcare systems fail to accommodate intersecting identities, perpetuating invisibility and emotional distress. • Need for inclusive policies to support people at the intersection of these identities.

Four themes emerged from the analysis process: "Reclaiming Sexuality: Breaking Stereotypes through Agency", "Navigating Constraints: Cultural, Institutional and Legal Factors", "Barriers to Awareness: Sex Education and Specialized Training Deficiencies", and "Building Inclusive Futures" (see Table 2).

Table 2. Themes identified through the reflexive thematic analysis process.

Themes	Records Included
Reclaiming Sexuality: Breaking Stereotypes through Agency	[10,30–35]
Navigating Constraints: Cultural, Institutional, and Legal Factors	[10,30–35]
Barriers to Awareness: Sex Education and Specialized Training Deficiencies	[10,30–33,35]
Building Inclusive Futures	[10,30–32,35]

3.1. Reclaiming Sexuality: Breaking Stereotypes Through Agency

In Morales et al.'s [32] study of heterosexual physically disabled women's sexual experiences, participants universally define sexuality as "a sensual act that passes through the mind and the emotions to reach the body" (p. 310) and as a fundamental human right "that everyone should have regardless of their physical condition" (p. 310). Likewise, women in Payne et al.'s [33] PhotoVoice study challenge their social portrayal as childlike asexual beings and pursue relationships seeking partnered sexual engagement, human connection, and intimacy. Institutionalized intellectually disabled women expressed a similar interest in sexuality, as documented by Fish [30].

Evidence of these women's eroticism emerged across all studies, with reports of desire for intimacy, masturbation practices, flirting, relationships, and sexual fantasies and activities. Morales et al. [31] analyzed the autoerotic practices of physically disabled men and women and recognized that all participants had a "physical need for such practices" (p. 423). All women reported masturbating regularly, depending on their mood, menstrual cycle, events of their lives, or relationship status [31,32]. Even though most of these women explored masturbation during adolescence, some only discovered these practices in adulthood, even if "their sexuality had awakened earlier" [32] (p. 309) due to the influence of cultural norms, history of abuse, or physical constraints. Their motivations for masturbating encompass love, sensuality, and affection, as well as therapeutic benefits like physical and mental relaxation, pain relief, improved sleep, and reduced anxiety. Solo sex also serves as a strategy to cope with the lasting impact of sexual abuse, enabling women to retrieve control over their own bodies and sexuality. Santos and Santos [10] emphasized the critical role these practices play in helping participants identify their individual optimal methods to achieve sexual pleasure.

However, disability imposes physical differences that might hinder these activities. Reduced dexterity, arm rigidity, muscle fatigue, cramps, hip inflexibility, lack of genital sensitivity and lubrication, spasms, and chronic pain might make it difficult for them to reach their genitals with their hands or use sex toys [31,32]. These barriers can lead to fear around orgasms and, thus, women ceasing stimulation before reaching climax [31,32]. Nonetheless, participants employ tactics that allow or facilitate their autoerotism, like creating a mood-inducing environment (e.g., candles, chocolates, putting on lingerie) or using adapted sex toys [31,32]:

> I stuck a meat fork into a carrot and covered the carrot in Saran Wrap to have some penetration (. . .) I had to organize things (. . .) and later, at the age of 43, I found a sex toy in a sex shop to stimulate the clitoris with different vibrations, so I took a long spaghetti fork and taped it onto it so I could use it with my hands [32] (p. 310).

Physical constraints may, similarly, interfere with partnered sexual activities, affecting leg abduction, movement control, and vaginal penetration. Nevertheless, just as they navigate motor barriers to engage in masturbation, disabled women develop adaptive strategies for sexual intercourse. This reflection of their agency, self-determination, reclaim of erotism, and rejection of the asexual label emerged in every study [10,30–35]. Santos and Santos [10] focused on the diverse re-sexualization experiences of disabled women, that is, their creative sexual maneuvers developed through experimentation "by removing the focus on genitals during sex and eroticizing other body parts, by adapting practices to the body, or by remapping places to have sex" (p. 8). Through trial and error, some participants found out they could turn their nape, nipples, and even scars into erogenous zones and get sexual stimulation from touching these areas. Others explored sexual positions that do not require leg spreading or use pillows to adjust the positioning of their bodies during coitus. Sometimes, they need to take breaks during sex or take painkillers beforehand. Deaf women opt to have sexual activities with the lights turned on. Blind women favor verbal communication during partnered sex [10].

> There was this phase of a new exploration of sexuality with a new body or with a body that had differences, and I remember there were some positions that I couldn't take . . .And yet, today I can say that I don't feel limited because we always find alternatives [laughs] and because everything is done, even if it's done differently from what we're used to . . .I like the position in which the man is behind . . .and it was not possible, because as I'm amputated above the knee there aren't two knees . . .And yet I found it was as simple as putting two or three pillows underneath [laughs]! But it wasn't as immediate as that. There was some frustration and sadness [10] (p. 9).

For women who acquired disability, living with motor differences becomes an opportunity for new and improved sexual fulfillment [10]. These women defend that by broadening the scope of sexuality beyond genitalia, the sensibility of other corporeal parts becomes enhanced, increasing the value placed on non-penetrative sexual acts and fostering the engagement and stimulation of their entire bodies during sex.

These findings contest the societal myths that represent disabled women as asexual, chaste, and passive. Instead, seeking to be recognized beyond ableist labels, these women assert themselves as sexual beings, capable of desiring and being desired. Some even use their disability as a tool in the seduction and flirtation process, embracing and emphasizing the uniqueness and differences in their bodies and sexualizing them, underlying empowerment and self-determination [10,33].

3.2. Navigating Constraints: Cultural, Institutional, and Legal Factors

While the impact of physical, sensorial, and neurocognitive differences is acknowledged, sociocultural factors are consistently described in the scientific literature as the primary obstacles to disabled women's eroticism and sexual citizenship [10,30–35]. The totalizing nature of the disabled label overshadows their other traits, namely, their sexual and gender identities [33,35]. Their disability is typically the first, and sometimes the only, characteristic other people notice about these women, perceiving them through ableist social stigmas and generalizations. Participants in Payne et al. [33] noted that most of their initial interactions with new people are narrowed to the topic of disability, and no attention is given to other life dimensions, making it more challenging for an intimate relationship to emerge from these early encounters.

Disabled women emphasize the significance of the asexuality myth, infantilization, and overprotection imposed upon them by family members, friends, educators, and healthcare professionals throughout their lives. The taboo surrounding sexuality, coupled with its perceived dangers, discourages these figures from engaging in discussions and open dialogues about human sexuality with these women, framed as innocent and vulnerable. This exclusion perpetuates the misconceptions about their eroticism and agency [10,31–33,35], hindering their ability to recognize, express and articulate their sexual and intimate preferences: "(. . .) the way I was raised, my mother said it was taboo, so as a kid I got my fingers smacked when she saw me masturbating" [32] (p. 308). Payne et al. [33] found that the general lack of understanding and support regarding sexuality contributes to feelings of loneliness and inadequacy in these women. Additionally, many reported negative self-esteem and body image issues, as their physical appearance often deviates from conventional beauty standards and sexual ideals [33]. Reinforcing the internalization of these norms, disabled women face rejection from prospective partners based on ableist prejudices. For instance, Peta et al. [34] explored the sexual experiences of a disabled woman from Zimbabwe, a cultural context where disability is a manifestation of evil spirits. The authors observed that she was rejected for being perceived as inferior, sexually incompetent, and unsuitable for a long-term relationship, even by disabled men. In response, she engaged in risky sexual behaviors, like unprotected penetrative sex despite her HIV-positive status, in an effort to satisfy her partner's expectations and sustain a long-term reciprocal intimate partnership. Participants in Payne et al. [33] elaborated on feelings of ambiguity when navigating intimacy. They expressed difficulties discerning mutual attraction, as ableist biases and the anticipation of being pre-judged through those lenses often triggered fear of rejection by their romantic or sexual interests. Consequently, some women distance themselves from intimate pursuits to avoid potential misunderstandings or negative experiences. Similar experiences were shared by Portuguese [10] and Polish non-heterosexual [35] disabled women. These accounts point to the pervasive impact of stigmas across diverse cultural contexts and identities and demonstrate the cyclical nature of these women's de-sexualization.

Wolowicz et al. [35] observed that these challenges are exacerbated for non-heterosexual women, as their sexual minority identities are outshone by their disability and associated presumption of non-sexuality. Furthermore, the dominant conceptualization of sexuality, narrowly defined as penis–vagina intercourse, reinforces their sociocultural invisibility. Within their families and social circles, their intimate relationships are misinterpreted as non-romantic and non-sexual, or perceived as a means to secure care and assistance in their daily lives. On the other hand, these women often conceal their sexual orientation, fearing the loss of support from queerphobic caregivers. These dynamics illustrate how ableism and heteronormativity intersect to constrain the sexual agency of disabled queer women, and how their marginalization operates not only through interpersonal relationships but is also structurally rooted in dominant norms about sexuality, intimacy, and care.

> A person like me has to overcome several difficulties. First, those around have to notice that a person in a wheelchair is a person, then an adult, and then that the person is a woman, and then, that the person is non-heteronormative [35] (p. 782).

Morales et al. [31,32] and Wolowicz et al. [35] pointed out the role of the religious upbringing of these women, particularly within Catholic traditions, in fostering guilt and shame surrounding sexuality. These feelings surface particularly associated with sexual acts not tied to reproduction, such as masturbation and non-heteronormative practices, which are deemed sinful in religious scriptures. This highlights the role of religious moral frameworks in shaping internalized sexual stigma, as well as their structural force in the regulation of disabled women's erotic autonomy.

Institutional policies and staff attitudes significantly influence the sexual expression of disabled women living in care facilities [10,30,35]. Condescendingly viewed as highly vulnerable and overly dependent on external support, women face constant surveillance and limited privacy, thus restricting their opportunities for sexual exploration [30,32]. Fish [30] exposes the gender biases embedded in this dynamic, noting that while personnel allow institutionalized intellectually disabled men to masturbate, women's sexuality is either overlooked or, when expressed, problematized. Staff categorize the sexual behaviors of disabled women within a predatory–vulnerable binary, framing their sexuality as inherently dangerous [30]. Moreover, these settings are "historically designed to limit the reproduction of disabled persons" [35] (p. 784), with residents usually segregated by gender, sexual intercourse prohibited, and rules strictly defining permissible physical contact [30,35]. These regulations not only restrict partnered sex but also negatively impact relationship satisfaction, causing frustration and isolation [30]. Nonetheless, such policies reflect a heteronormative logic of sexuality and intimacy, suggesting that non-heterosexual relationships are either disregarded or deemed irrelevant, as they do not lead to pregnancy [35]. However, non-heterosexual sexual expression is still condemned, as public institutions in Poland commonly operate through homophobic norms, further marginalizing queer disabled women's sexual rights [35].

> I was sent to a psychologist. I just told her I had a girlfriend [. . .]. I was called to the principal's office, and they asked me whether I was a lesbian, which I thought was quite shocking at the time. And when I nodded, I had to sign a letter that I would go for treatment [. . .]—it was something like conversion therapy [35] (p. 785).

Wolowicz et al. [35] also explored the impact of the Polish legislative context, particularly the lack of legal recognition for non-heterosexual partnerships and the absence of anti-discriminatory protection, on the autonomy and access to intimate experiences for disabled women. In Poland, people in queer relationships are formally single, which means that non-heterosexual couples are excluded from the legal protections available to heterosexual married couples. As a result, non-heterosexual disabled women face heightened social and economic precariousness, as they are denied access to caregiving, financial security, and inheritance rights [35].

3.3. Barriers to Awareness: Sex Education and Specialized Training Deficiencies

The generalized silence and ignorance surrounding sexuality and sexual health were uncovered by most studies [10,30–33,35]. While both disabled men and women reported receiving little to no sexual education [31], the aftermath appears to be more pronounced for the female participants. All male participants were able to identify the organs they stimulated during masturbation accurately and understood how their bodies worked. In contrast, most women lacked basic anatomical knowledge or the vocabulary to describe their solo-sex practices and were unable to distinguish and locate certain body parts [31]. These findings reveal the influence of gender stereotypes on these experiences. The desexualization of disabled people is reinforced by gender expectations tied to femininity, like sexual passivity, fragility, purity, and modesty, whilst contrasting with men's role of sexual assertiveness, conquest, and dominance [9,36,37]. Therefore, disabled men often receive more support for their sexual agency. They are more likely to discuss sexuality with their peers openly, have more resources available, and are assisted in engaging with erotic materials, such as pornography, or seek sex workers' services. On the contrary, disabled women are generally not encouraged to normalize their relationship with sexuality [31].

> I felt like a real idiot compared to other people, lots of them are younger than me, then someone was talking about the G spot and I had no idea what it was (. . .) I don't even know where the clitoris is [32] (p. 308).

Despite their family members' and caregivers' illiteracy and anxieties surrounding sex education, most participants in Santos and Santos' [10] study criticize the lack of specialized training for sexuality and diversity. Sexual health services fail to address the needs and concerns of disabled women, as healthcare providers typically receive limited education on human sexuality and even less on the intersection of sexuality and disability. These services, as well as the sexuality education programs, are designed and structured for the cis-heteronormative and able-bodied ideal of sexual expression [35], focused on penetrative sexual acts. As a result, these figures hold and perpetuate the ignorant and ableist assumptions socially prevalent, giving disabled healthcare users unequal treatment, avoiding discussing, or even disregarding, their questions related to sex and sexual health. Such patterns reveal how inequality is reproduced by specialized professionals, who implicitly deny disabled women full sexual citizenship and reinforce systemic neglect in care provision.

> I found an absolute ignorance amongst gynaecologists about sexuality of disabled women, particularly spinal cord injuries acquired. In their minds we have no pleasure, nor should we have children, because it only gets complicated, due to their misinformation. For example, I had to educate my gynaecologist about this matter. And concerning psychologists and psychiatrists, it is the same. It remains a taboo subject [10] (p. 6).

The lack of access to comprehensive sexuality education significantly impacts these women's sexual satisfaction, sexual health, and sexual citizenship, and sustains their socio-sexual marginalization and segregation. Disabled women internalize social prejudices and the dominant hetero-reproductive discourse of sexuality [10]. In the absence of opportunities to contest these societal misconceptions, they are deprived of critical knowledge that would enable them to explore intimacy confidently and make informed decisions about their sexual health [10]. With limited information about their own anatomy and sexual functioning, these women encounter additional barriers in discovering their bodies' pleasure, exploring non-penetrative sex, finding comfortable positions, and achieving orgasm, even when resorting to autoerotic practices [10,32]. These women are also at heightened risk for unwanted pregnancies and sexually transmitted infections. Ironically, their increased vulnerability to sexual abuse can be explained by their exclusion from these discussions, as they do not learn about consent or about which body parts are private [7]. Due to the constant physical touch required for third-party assistance in daily activities, such as personal hygiene, disabled people may feel ambiguity regarding physical boundaries. Additionally, their unfamiliarity with anatomical terminology may complicate the process of reporting sexual abuse occurrences.

3.4. Building Inclusive Futures

Drawing from participant reports and shared experiences, several authors [10,30–32,35] alert to the urgent need for policies and interventions aimed at fostering disabled women's sexual well-being, autonomy, and rights.

> [. . .] people with disabilities must have access to sexual education that meets their specific needs. We also believe that a specific recognition of their needs must be applied when education programs are being formulated so they can develop sexual skills to meet those needs [32] (p. 312).

The substantial gaps in knowledge and ignorance surrounding sexuality and disability highlight the critical need to develop comprehensive educational resources, guides, and materials that address these intersections. Of equal prominence is investing in specialized training programs to equip healthcare professionals and educators with the expertise to support the sexual health needs and well-being of these women effectively. Furthermore, researchers suggest improving and broadening the content of sex education curricula and ensuring inclusive programs in schools, hospitals, rehabilitation centers, and other pertinent settings [10,31,32,35]. Through these efforts, authors believe the discourse and construction of sexuality can be reshaped to include and recognize these women as sexual citizens.

> The creation of an expanded discourse on sexuality and more egalitarian modes of expression in rehabilitation institutions, as well as in the general public, are necessary and could be made possible through the use of technology (websites, mobile applications, virtual reality, etc.). Another solution might be the creation of specialized technical aids or sex toys [31] (p. 428).

Morales et al. [31] advocate for the development and commercialization of affordable and specialized sex toys specifically adapted to enhance disabled women's pleasure practices. Their study identified several restrictions participants face when attempting to use erotic devices, such as the risk of injury, difficulty cleaning, inaccessible controls, and high cost. All participants expressed interest in resorting to inclusive sex toys as "therapeutic tools" [31] (p. 427) to facilitate erotic stimulation. The scholars further reflect on the potential benefits of legalizing sex work in supporting the sexual autonomy and health of disabled people. Although none of the female participants engaged with the sex industry, one expressed a willingness to if such services were legalized and provided in a safe, non-exploitative manner [31]. The study also revealed that disabled men who accessed commercial sex reported higher levels of bodily awareness, improved body image, and greater overall well-being [31].

> [. . .] the fact that sex workers' services are not legalized in our society or are otherwise controversial, makes some people reluctant to use them. As for the biopsychosocial benefits of masturbation, this study also observed that this activity can improve health, foster bodily learning and enhance body image [31] (p. 427).

4. Conclusions

The 25th article of the United Nations Convention on the Rights of Persons with Disabilities concerning the Right to Health requires States' Parties to provide disabled people equitable access to health care of the same quality and standard delivered to non-disabled people, including sexual and reproductive health services [16]. However, our findings expose the gap between these commitments and disabled women's lived realities.

While there is no denying that the civil rights and independent living movements led to significant progress and social change regarding disabled people's rights [38], much remains to be achieved in the realms of life not directly related to survival, like sexuality, particularly for women. Scientific research displays numerous manifestations of resistance and agency amongst disabled women, as they navigate stereotypes and misconceptions surrounding their erotic lives, reclaim their sexualities, and tailor their experiences of intimacy to their bodies and pleasure [10,30–35]. By mapping and documenting the concrete strategies disabled women use to achieve pleasure, this review moves the focus from limitations to possibilities. It offers a practical resource for healthcare professionals, therapists, and other educators by identifying specific accommodations (e.g., alternative sexual positions, use of supports like wedges or pillows, adapted sex toys) that can be recommended to foster disabled women's sexual well-being.

However, it is important to be cautious when interpreting these findings to avoid generalizing them to all disabled women. Only seven records met the criteria to be included in this synthesis, reflecting the scarcity of research about the practical aspects of these women's sexual lives. Furthermore, these studies relied on qualitative methodologies, producing culturally and geographically situated data, drawn from small and non-representative participant samples. Disability can impact different bodies in different ways, and intersecting identities, such as race, class, age, and religious beliefs, as well as the level of sexual education, access to resources, and the quality of their personal relationships, further shape these women's sexual experiences. Therefore, the narratives explored may not represent the full range of experiences of disabled women, making it entirely possible that some of them practice conventional sexual acts aligned with cis-heteroreproductive societal norms, such as partnered penetration. Trans disabled women's voices are also notably absent from the analyzed research, since studies addressing this intersection focus on stigma, violence, and disparities in healthcare access [19], with little attention given to how these women navigate sexual pleasure.

Due to the massive diversity of experiences among disabled women, there is a pressing need for research that employs participatory and intersectional approaches to fully understand and capture their realities. Another key limitation of this study is that none of the authors identify as disabled. As a result, the analysis does not include the lived and embodied understandings that are essential to comprehensively grasp the experiences of disabled women. Research led by disabled women is crucial to ensuring accurate representation, in line with the principle "nothing about us without us" [39]. Such contributions are essential for developing evidence-based policies and interventions that promote sexual health, autonomy, and rights of this population. Collaboration between the technological, healthcare, and social sciences sectors is also critical to advance innovations that support disabled women's sexual agency and access to pleasure. This includes the development of a wider range of options of adapted sex toys, pharmacological options that assist sexual function and pleasure, strategies to build sexual self-efficacy, and educational resources. Adopting an interdisciplinary framework is necessary to address disabled women's sexual well-being in a practical, inclusive, and affirming way.

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Notes

[1] Sexual citizenship integrates sexual rights into the broader framework of citizenship. This concept emphasizes people's ability to express their sexuality and make informed decisions regarding sexual identity, relationships, and health; recognizes sexual diversity and the safeguarding of sexual rights, particularly for marginalized groups; and underscores the principles of sexual autonomy, equality, and participation in sexual life, free from discrimination and exclusion [5,6]. Sexual citizenship draws attention to the structural inequalities that influence sexual experiences, advocating for social justice to ensure people's fundamental sexual rights.

[2] Romañach and Lobato [27] proposed "functional diversity" as a linguistic shift to refer to the natural variation in how human beings interact with their environment, encompassing physical, sensory, intellectual, and psychological differences. This terminology moves beyond medicalized or deficit-focused language, like disability, and frames diversity as a normal and dignified part of human existence. More common in Spain and Portugal, functional diversity aligns with a rights-based approach, emphasizing autonomy, social inclusion, and dismantling barriers imposed by structural ableism. By focusing on functionality as a spectrum rather than categorizing individuals based on impairments, this concept seeks to foster respect, equity, and recognition of individual capabilities.

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