Revista Chilena de Fonoaudiología. Número Especial, 2025
https://revfono.uchile.cl/
ISSN 0719-4692

Original Article

Women, Disabilities and Sexualities: An Intersectional Perspective from Health Discourses

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ABSTRACT

This research set out to explore how experiences related to the sexual health care of women with disabilities are shaped in health services in Cali, Colombia, in 2023, based on the discourses of women with disabilities using health services, as well as health professionals. A narrative study was conducted, drawing on interviews with two women with disabilities and five professionals from various health disciplines who work in academia. The data were analyzed based on predefined categories and the theoretical framework guiding the study, which includes: "discourses" as mechanisms for the creation and reproduction of practices, as well as concepts of "sexuality", "the body", "gender", and "disability" from feminist and critical theory perspectives. The findings reveal that hegemonic discourses emerge, persist, and are reproduced within the practices of health professionals. These discourses act as psychosocial, physical, and communicative barriers, constituting forms of unacknowledged violence that impact bodies and identities. These dynamics contribute to multiple forms of discrimination, limiting and stereotyping the sexual expression of women with disabilities. We conclude that speech-language therapy must engage critically with the discourses circulating within the health system. It is essential to rethink the meanings and signifiers for a process that reclaims bodies, disabilities, and sexualities not merely as social categories, but as tangible realities.

Keywords:
Women and Sexuality; Body; Disability; Discourses; Health System and Sexuality

Mujeres, discapacidades y sexualidades: una mirada interseccional desde los discursos en salud

RESUMEN

En esta investigación nos propusimos recoger, a partir de los discursos de mujeres con discapacidad usuarias del servicio de salud y profesionales de la salud, cómo se configuran experiencias sobre la atención a la sexualidad de mujeres con discapacidad en los servicios de salud en Cali, Colombia en el año 2023. Se realizó un estudio de tipo narrativo centrado en los relatos recogidos a partir de entrevistas con dos mujeres con discapacidad y con cinco profesionales de distintas áreas de la salud que se desempeñan en el ámbito académico. La información recogida se analizó de acuerdo con las categorías y a las consideraciones teóricas propuestas para el estudio: "discursos", como mecanismo de creación y reproducción de prácticas, así como "sexualidad", "cuerpo", "género" y "discapacidad", desde posturas feministas y teorías críticas. Los hallazgos revelan que en el ejercicio de les profesionales de la salud nacen, se perpetúan y reproducen discursos hegemónicos, que se convierten en barreras psicosociales, físicas y comunicativas, en violencias no asumidas que inciden sobre los cuerpos e identidades, produciendo factores de múltiple discriminación que limitan y estereotipan el ejercicio de la sexualidad de las mujeres con discapacidad. Esto permitió concluir que desde la fonoaudiología es indispensable acercarse de forma crítica a los discursos circundantes en el sistema de salud, repensar los significantes y significados, en un proceso de reivindicación del concepto de los cuerpos, las discapacidades y las sexualidades, no sólo como categorías sociales sino como realidades tangibles.

Palabras clave:
Mujer y Sexualidad; Cuerpo; Discapacidad; Discursos; Sistema De Salud y Sexualidad

Mulheres, deficiências e sexualidades: Um olhar interseccional desde os discursos na saúde

ABSTRACT

Nesta pesquisa foi proposto recolher, a partir dos discursos de mulheres com deficiência, usuárias do serviço de saúde, e profissionais de saúde, como é que são configuradas experiências sobre a atenção à sexualidade de mulheres com deficiência nos serviços de saúde em Cali, Colômbia no ano de 2023. Foi realizado um estudo de tipo narrativo centrado nos relatos recolhidos a partir de entrevistas com dois mulheres com deficiência e com cinco profissionais de diferentes áreas da saúde que atuam no meio académico. A informação recolhida foi analisada de acordo às categorias e às considerações teóricas propostas para o estudo: "discursos", como mecanismo de criação e reprodução de práticas, "sexualidade", "corpo", "gênero" e "deficiência", desde posicionamentos feministas e teorias críticas. As descobertas revelam que no exercício dês profissionais da saúde nascem, perpetuam-se e são reproduzidos discursos hegemônicos, que se convertem em barreiras psicossociais, físicas e comunicativas, em violências não assumidas que incidem sobre os corpos e identidades, produzindo fatores de múltipla discriminação que limitam e estereotipam o exercício da sexualidade das mulheres com deficiência. Isto permitiu concluir que desde a Fonoaudiologia é indispensável se aproximar de forma crítica aos discursos circundantes no sistema de saúde, repensar os significantes e significados, num processo de reivindicação do conceito dos corpos, as deficiências e as sexualidades, não só como categorias sociais, mas como realidades tangíveis.

Palavras-chave:
Mulher e Sexualidade; Corpo; Deficiência; Discursos; Sistema de Saúde e Sexualidade

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Received: 06-26-2024
Accepted: 04-01-2025
Published: 07-17-2025

INTRODUCTION

Intersectionality can be defined as the overlapping forms of discrimination that a person may experience when multiple social categories intersect to produce inequality. Categories such as class, gender, ethnicity, disability, or sexual orientation, when interwoven and relationally constructed, become sources of oppression (Platero, 2012; Ferrándiz-Armero, 2016).

This study uses the concept of intersectionality to highlight types of oppression happening simultaneously—specifically, in the case of women with disabilities. This is a crucial perspective as this population's sexuality is often targeted through multiple, intersecting dimensions. Rather than viewing the violence experienced by women and by disabled people as separate, we emphasize the convergence of identities: being a disabled woman who experiences, or seeks to experience, her sexuality. We also acknowledge that these realities are further shaped by additional identities such as race, gender expression, sexual orientation, political positioning, and class. These identities fall beyond the full scope of the present analysis.

We aim to engage with disabled women's narratives through the multiple layers that both structure their lived experiences and function as mechanisms of domination, ultimately restricting access to their sexual and reproductive rights. Accordingly, this research explores the intersection between gender, disability, and sexuality, as voiced by disabled women's realities as sexual beings.

We begin by addressing gender, a concept that stems from the anatomical differences between men and women—particularly the sex assigned at birth by healthcare professionals. From this designation, societies have traditionally derived a set of interpretations that attribute intellectual, spiritual, and physical abilities, social roles, and rights that are not only differentiated but categorized as first- and second-class (Herrera, 2021). Within this hierarchy, societies have devised complex control mechanisms to limit what women can be and do, requiring them to conform to traditional roles such as homemaker, mother, caregiver, and companion, while simultaneously expecting productivity, resilience, and perfection.

Gender, then, is understood as a product of culture and education that, although derived from biological difference, is not rooted in it. Instead, it is constituted by a "set of practices, beliefs, representations, and social prescriptions that emerge among members of a human group based on the symbolic interpretation of anatomical differences between men and women" (Lamas, 2000, p. 3). On this basis, locations and tasks are socially organized and distributed as “masculine” or “feminine” in a dichotomous, essentialist, and hierarchical manner (Musto, 2014, p. 359).

Gender and the body are two interrelated constructs that are both social and political products. They operate as forms of power that distinguish between what is deemed "normal"—the standard—and what is considered "different," framed as an error, deficiency, or deviation that must be corrected or normalized. In this context, disabled women are positioned as failing to fulfill the functions or roles prescribed by the system: they are framed as unproductive, uncaring, unfeminine, undesirable, dependent, and incapable of reproducing more normative bodies (Foucault, 1999; Luditas Sexxxuales, 2015; Maldonado, 2023; Manada de Lobxs, 2015).

Gender thus becomes a regulatory ideal for the construction of embodiment, where discourse (systems of signs) about masculinity and femininity are mechanisms of control that model how bodies are expressed, along with techniques that homogenize sexual identities (Manada de Lobxs, 2015). These imaginaries, powerful discourses, and constructions of gendered embodiment establish normative identities within which disabled women are perceived as disruptive or unsettling.

Sociological and feminist theories call for the deconstruction of exclusionary frameworks and the construction of diverse identities, asserting that “the subject of knowledge is a particular historical individual whose body, interests, emotions, and reason are constituted by their specific historical context and are especially relevant for epistemology” (Guzmán & Pérez, 2007, p. 327). These approaches seek to introduce feminist aims and perspectives into discourse, positioning women as subjects for whom political representation is pursued (Butler, 2007).

Societies organize themselves—and we wish for them to do so—around the concept of "woman" to create space for diversity, thereby conceptualizing “femininity and masculinity as indeterminate, mutable, and modifiable according to the kind of society we wish to build” (Lagarde, 1994, p. 25). Recognizing gender and the body as social constructs opens the possibility of rethinking the practices that produce and reproduce them (Jones et al., 2015).

Research on disabled women’s bodies reveals that non-normative corporealities are perceived as health problems within the biomedical framework. This outlook perpetuates discourses that legitimize violent and exclusionary practices, rendering these women invisible and restricting their participation. Therefore, marginalized people increasingly defy the status quo to shift toward alternative discourses. From a social model, disability is defined as “a social phenomenon, the result of conditions that shape the daily lives of people with disabilities, producing obstacles, marginalization, and exclusion. It is society itself which is disabling, through preconceived ideas, stigmas, and prejudice” (Ferreira, 2007, p. 10).

Disabled bodies, positioned outside the norm, demand alternative definitions—not only to establish what disability is or its implications, but also to address the political and practical issues that directly affect the lives of those who experience it. Individual factors, contextual barriers, and enabling conditions interact to shape autonomy and participation. Revuelta and Hernández propose understanding disability as a form of oppression by “recognizing and highlighting the inferior position of people with disabilities relative to others in society, and by showing that this position is tied to ideologies that justify and perpetuate it” (2021, p. 18).

Even though one-sixth of the global population lives with a disability (World Health Organization [WHO], 2023), biopower discourses persist, resulting in the restriction, discrimination, violation, exclusion, and desexualization of disabled people. As Maldonado (2023) argues, the health system itself has “historically enacted violent practices toward sexual diversity,” a point emphasized in their presentation at *Simposio de Investigaciones en Salud* in Cali, Colombia.

The violation of disabled women’s rights—our third key concept—is systematic, particularly in relation to sexuality. Rooted in traditional ideological models, this violation restricts their ability to experience their sexuality openly outside of procreation, while reinforcing myths that portray them as asexual, dependent, or pitiable. Consequently, their sexuality is often acknowledged only in reproductive terms.

The WHO and UNESCO place sexuality as a central dimension of human life. Beyond sexual relations, it encompasses psychological, social, biological, and cultural aspects. It involves identities, bodily awareness, gender roles, eroticism, pleasure, intimacy, sexual orientation, affective bonds, love, and reproduction (WHO, 2006; UNESCO, 2018). When discussing sexuality and sexual rights, it is therefore essential to focus on discourses and how information is shared and transmitted. Sexuality is a lifelong, evolving process, constructed and experienced through social interaction. It is, as Bejarano-Franco et al. (2021) describe, a “multidimensional aspect interwoven across the various facets of human existence” (p. 2).

Sexuality is not synonymous with sexual intercourse, nor is it limited to the presence or absence of orgasms or erotic experiences. It is better understood as an inalienable right, linked to each person's ability to choose and decide, individually and autonomously, how to express themselves (Clos & Deulofeu, 2022). While eroticism and sexual activity may form part of sexuality, they are not required for it. Sexuality is diverse, shaped differently by each person and across different life stages. It plays a vital role in interpersonal, emotional, and social well-being. As Langfeldt and Porter (1986, as cited in Boccardi, 2020) put it:

> "It is in the energy that motivates us to find love, contact, warmth, and intimacy. It is expressed in the way we feel, move, touch, and are touched. It is about being sensual as well as being sexual. Sexuality influences thoughts, feelings, actions, and interactions and thereby our mental and physical health" (p. 16).

Critical disability studies offer emancipatory perspectives, insisting on the need for "cross-cutting reflections that challenge how society is constructed. From disability, it becomes possible to understand the regulatory mechanisms that dismiss the variability that 'disrupts' the truth that normalizes and standardizes bodies" (Revuelta & Hernández, 2021, p. 19).

Revuelta and Hernández (2021) propose an intersectional perspective that considers multiple identities through the lenses of feminism and disability. They distinguish among sex, sexuality, and disability, noting that the public dimension of disability has been developed more extensively than the private and emotional dimensions, which concern the lived experiences of subjects who are far from homogeneous. Just as reproduction is restricted or curtailed, healthcare professionals often regulate the manifestations of sexuality.

When sex and disability intersect, health institutions treat women's physical conditions as problems to resolve or normalize. At the same time, they pay little attention to this intersectionality as a framework for ensuring the full practice of sexual activity and pleasure.

> "Sexuality is a symbolic universe built upon a biological reality—sex—emerging from a complex interplay of physiological structures, behaviors, experiences, emotional attachments, interpretations, social practices, and power dynamics. Linguistically, sex may be seen as the signifier, while sexuality represents the set of affective, practical, or ideological meanings attributed to it" (Marina, 2002, p. 31).

Discourses, which are both part of the field of speech-language therapy and the guiding thread of this study, are defined as "linguistic forms activated to construct modes of communication and representations of the world" (Palacios-Sierra & Sierra, 2011, p. 387). They are more than a set of linguistic resources that represent reality: discourses build, maintain, replicate, and reinforce the various interpretations of social representations, social practices, and human relations. They strengthen and generate meaning, structuring fields of knowledge and action. At the same time, discourses operate as mechanisms of control, producing inequality depending on who speaks, where, and under what conditions.

Foucault (1971) argued that discourse circulates under restriction, mediated by rules and conditions that regulate, authorize, or disauthorize it, in order to preserve social order and safeguard the legitimacy of those validated by dominant social groups. As a result, we are conditioned to replicate and constantly engage with hegemonic discourses until we internalize them as our own, as truth and knowledge, shaping our everyday actions.

Speech-language therapy must contribute to the validation of alternative discourses that recognize diverse, non-normative female bodies, distinguishing between reality and social constructs while challenging traditional roles of femininity. Within healthcare systems, this implies developing practices and discourses attentive to the intersecting needs of each person. This concern shapes the central research question: *What place does sexuality occupy in the discourses of health professionals and disabled women, as informed by their experiences within healthcare?*

A discursive transformation is needed—one that acknowledges sexuality as diverse and non-normative, reflecting multiple lived realities, embodiments, and roles. Such an approach affirms sexuality, encompassing sex, affectivity, and physical exploration and recognition, as a fundamental right for disabled women (Aponte & Eslava, 2008).

General Objective

To unveil the place of disabled women's sexuality within their discourses in the context of health services and the discourse of health professionals working in academic contexts.

Specific Objectives

- To examine how disabled women experience and voice their sexuality within healthcare settings.
- To identify how health professionals construct and reproduce discourses on the sexuality of disabled women.

METHOD

Design

We selected a biographical narrative design, "whose object is the narratives collected in interactive dialogue, through observational data, narratives told by informants, narratives heard by the researcher, and theoretical models" (Bolívar, 2012, p. 2). This approach is sensitive and flexible, allowing for the analysis of diverse perspectives and discourses concerning women, disability, and sexuality within a system, in this case, the healthcare system.

Participants

For the first group (health professionals working in academic settings), we conducted an initial search on the Faculty of Health Sciences' website at Universidad del Valle, Cali, Colombia. We identified schools and reviewed the curricula of nine academic programs. From this information, a database was created, including the following details: courses related to the research topic, semester in which each course is offered, areas of knowledge, full names of faculty members, their research interests or lines of inquiry, and contact emails.

We selected programs from the database whose healthcare practice was most related to the study's focus, ensuring relevant experiences and communicative interactions for analysis. We then sent invitations to participate, receiving responses from the following programs: Nursing, Occupational Therapy, Physiotherapy, Pre-Hospital Care (women), and the Medical Program Management (a man) at Universidad del Valle, Cali, Valle del Cauca, Colombia.

The group consisted of four women and one man, aged between 47 and 57 years. All held current healthcare qualifications and had over 20 years of university teaching experience in clinical settings. Their professional trajectories included providing care to disabled women in outpatient, emergency, and intensive care contexts.

A brief profile of each participant at the time of fieldwork is provided below:

The first participant, a female head nurse, is affiliated with the Nursing Care Society for Sexual and Reproductive Health (*Cuidado de Enfermería para Salud Sexual y Reproductiva*). She holds a Master's degree in Nursing with a specialization in Maternal-Child Health. Her research interests focus on pedagogy for care.

The second participant is a physiotherapist specialized in cardiorespiratory therapy from an institute in Brazil. Her research interests focus on cardiopulmonary physiotherapy. Additionally, she is a member of *Sociedad Española de Neumología y Cirugía Torácica* (SEPAR).

The third participant is a physician and surgeon trained at a public university in Cali, who completed her specialization in critical care and intensive medicine at a private university. She also holds a master's degree in sustainable human development with an emphasis on care and disaster prevention.

The fourth participant holds a professional degree in occupational therapy, a specialization in child psychology, and a master's degree in philosophy. Her areas of interest include occupational intervention in the educational sector and human development.

The fifth participant is a physician and surgeon specialized in family medicine from a public university. He also holds a master's degree in education from a private university. His research lines focus on medical education and primary care. Moreover, he is a member of the Colombian Society of Family Medicine (*Sociedad Colombiana de Medicina Familiar*).

Regarding Group 2 (disabled women), information was collected through websites, blogs, and social media, using the following search variables: woman, disability, sexuality, and Cali. The aim was to identify organizations, collectives, support groups, or institutions that address issues related to sexuality, working with women, populations with disabilities, or with any intersection of these characteristics in Cali.

We then created a database that included the following information: name, type of entity, whether they work with women, whether they work with people with disabilities, whether they address issues related to sexuality, the name of their legal representative, contact method (social media, email, or phone number), and address. A recruitment email was drafted, including an infographic and an attached document presenting the study's purpose, expected participation time, fieldwork methodology, aspects to be analyzed, and general information about informed consent.

Subsequently, thirteen emails and three social media messages were sent to institutions, collectives, or organizations that work with women, people with disabilities, or focus on sexuality. These communications requested contact information for potential participants. Upon receiving responses to the initial emails, all research-related information was resent to interested parties.

Sixteen follow-up phone calls were made to organizations that did not respond to the initial contact attempts to confirm reception of the information. As a result, in-person meetings were arranged with two women to obtain informed consent and conduct in-depth interviews.

Based on these procedures, Group 2 was composed of two women with a single disability diagnosis. This aligns with the inclusion criterion of one disability only, ensuring that each participant could actively and autonomously communicate during the interviews. Both participants had acquired physical disabilities and were wheelchair users.

The first participant, a 45-year-old woman, completed her social work qualification and holds a postgraduate degree in sociology from a public university in Cali, Colombia. She identifies as a disabled woman, a wheelchair user, a feminist, a lesbian in a marital union, and an activist for the rights of disabled women. She currently works as a university professor and participates in projects related to disability rights activism. Her disability is certified by a physician, a physiotherapist, and a psychologist through the Ministry of Health and Social Protection of Colombia.

The second participant (47 years old) is the president of the Community Action Board (*Junta de Acción Comunal*) of the Puertas del Sol neighborhood in Cali. She also serves as a representative of the Local Disability Committee and as secretary of the Association of Community Action Boards of District 14. She is currently pursuing a training program in Health Administrative Assistance at a public institution in Cali. She identifies as a Black woman with a physical disability, a wheelchair user, and an activist for the rights of disabled women. She is single, a mother of two daughters, and a grandmother. Her disability is certified by the regional disability evaluation board of Valle del Cauca.

Participant recruitment was challenging despite the use of multiple communication channels to disseminate the invitation. This was particularly true for the group of women with disabilities, for which a “snowball” sampling technique was employed to recruit additional participants with close connections to the already interviewed women. However, this strategy was unsuccessful, as potential participants reported that the topic was not one they could discuss comfortably or confidently on record.

Table 1. **Inclusion and Exclusion Criteria**.

Inclusion Criteria	
Group 1 Health Professionals	Group 2 Disabled Women
Professionals currently providing services within the healthcare system.	Adult women with a medical disability diagnosis, registered in *Registro para la Localización y Caracterización de las Personas con Discapacidad* (RLCPD).
Professionals working in health fields such as Speech-Language Therapy, Occupational Therapy, or Physiotherapy.	Women who can communicate their personal narratives, either independently, with an interpreter, or using a communication tool.
Directors of academic programs within the Faculty of Health at a public university.	Women registered with the healthcare system, either under the contributory or subsidized regime.

Exclusion Criteria	
Group 1 Health Professionals	Group 2 Disabled Women
Health professionals in training or those who have not provided care to disabled women.	Women with multiple disabilities.

Instruments

Semi-structured, in-depth interviews were conducted. Robles (2011) defines an in-depth interview as a qualitative data collection method that enables the researcher to situate social phenomena. It involves face-to-face interaction, enabling the exploration of relevant information in real-time for broader analysis. Moreover, it fosters trust, which is essential for the development and construction of data. The purpose of this method is to:

> “delve into the life of the other, penetrate and detail what is transcendent, decipher and understand the interviewee’s tastes, fears, satisfactions, anxieties, worries, and joys that are meaningful and relevant; it consists of building, step by step and meticulously, the other person’s experience” (Robles, 2011, p. 2).

This instrument was used to explore language as a symbolic mediator of meaning in discourse. It allowed us to collect comprehensive information about the discourses within the healthcare system, from the perspectives of both service providers and academic instructors, as well as the disabled women receiving support. The analysis thus recognized and contrasted the discourses arising from these two realities.

For Group 1, questions explored the conceptions of disability that the participants employ in their professional practice. The interviews also explored perceptions of the body and sexuality that underlie their academic and professional experiences. Additional open-ended questions were derived from these initial responses, focusing on current interventions and discourses.

For Group 2, questions were organized into three topics: (1) personal and sociopolitical information, (2) health and disability status, and (3) experiences of care or support received from healthcare providers regarding sexuality. These participants served as the primary sources of information, and their accounts informed the design of the interviews with Group 1. This approach allowed for a comparative analysis of discourses circulating in the healthcare sector.

Procedure

The research was conducted in three phases:

1. ***Preparation***

Identification and contact with the groups were carried out using the methods described in the Participants section above.

2. ***Correspondence***

In-person meetings were held to introduce the study, obtain informed consent for audio recording, and administer data collection. Group 1 completed the survey via Google Forms, with an opportunity to clarify doubts or expand their responses. For Group 2, the in-depth interviews examined the life experiences of participants within the healthcare system, specifically in relation to their gender and sexuality.

3. ***Analysis and Discussion***

All audio-recorded material (approximately four hours) was transcribed to create categories and analyze results in alignment with the study's objectives. The analysis was enriched through a cross-sectional analysis of relevant documentation. Reading these texts strengthened the study's poststructuralist perspective, particularly concerning biopower and feminist critiques, identifying the role of sexuality in the discourses of both groups. Finally, the three researchers engaged in introspective and autobiographical narrative exercises, reflecting on our own intersecting identities. This process aimed to unveil experiences shaped by practices and discourses within a patriarchal, heteronormative, and ableist system, which enforces stereotypes regarding beauty, ability, sexuality, and race linked to gender. In turn, this creates frameworks of oppression, discrimination, and violence. Through this lens, participants were encouraged to view their bodies as sites of resistance.

Ethical Considerations

According to Resolution No. 8430 of the Colombian Ministry of Health, this research poses minimal risk. The study was approved by the Ethics Committee of the Faculty of Health Sciences at the university. Participant confidentiality was ensured through coding and restricted access to data, which was used solely for academic purposes. Group 2 participants were contacted directly and fully informed about the implications and potential risks associated with their participation. The informed consent forms (see Appendices 1 and 2) specified the required attendance at scheduled meetings and consent to audio recording. This research benefits participants by providing them with an active role and contributing to knowledge on the health and sexuality of disabled women.

RESULTS

Sexuality Discourses Reflected in the Experiences of Disabled Women From Their Own Voices

As part of this study, we witnessed two resilient women who face daily communicative, structural, and systemic barriers rooted in hegemonic discourses that have been reproduced through the years. These normalizing discourses are so deeply entrenched in individual and institutional practices that they permeate the healthcare system, which, despite presenting itself as providing comprehensive care, creates barriers that hinder this practice. This manifests in the accounts of the interviewed women.

> "Pap smears, oh, the pap smears—it's a crazy thing. At least in Cauquita it happened a lot: the security guard had to help me. So I would ask, why? They always schedule pap smears with women who have weak shoulders, those with delicate health conditions, who cannot exert strength. Then they have to find someone among the people outside to help lift me onto that high table to collect the sample. I told them one day, 'this is violence against us, because

> what's missing is for the guard to pull my pants down'" (M1M).

Throughout the conversations, the women consistently expressed a feeling of "invisibility regarding access to pleasure, eroticism, and sexuality itself" (A2M).

The bodies of women with disabilities are not viewed as whole or autonomous; instead, they are seen as fragmented, their needs are invalidated, and their specific sexual realities are ignored. One participant stated "…sexuality is such a precarious aspect that it hasn't even been named—neither in the healthcare system nor within families, as if women's sexuality were something easily forgotten" (A2M).

The interviewees also mentioned numerous taboos and myths that overshadow their experiences and needs when interacting with the healthcare system, resulting in discourses and behavioral patterns that perpetuate violence.

> "I don't know if we could call it obstetric violence, but a doctor, when he asked about my sexual orientation, also asked about my pap smear. I told him I hadn't had one. Then he asked if I wasn't having sexual intercourse, and I said yes, that I had an active sexual life. Then he asked why I wasn't using contraception, and I told him I was a lesbian. I was actually there with my partner. When he heard that, he said, 'Have you seen nymphomaniacs?'" (A2M).

However, inhabiting bodies that have become sites of resistance, the women also expressed alternative discourses and practices that challenge the persistence of the traditional ideological model linking female happiness or fulfillment to having a partner. They highlighted how society maintains the expectation that women should establish a family, saying "it's as if women's bodies were only thought of for procreation, and nothing beyond that" (A2M).

Such discourses, replicated within the healthcare system, neglect critical issues when providing care and information to other bodies—such as the specific implications of a disability diagnosis for sexual expression—leading this population to create spaces of resistance. Women start groups that aim to change or generate new discourses from lived experience:

> "Because society, doctors believe that people with disabilities don't feel… When I ended up in a wheelchair, I realized I was still beautiful. I started fixing myself up, wearing perfume, putting on makeup. I started to know and love myself" (M1M).

When the interview topic shifted to communicative barriers and the group of health professionals, the women subtly portrayed them as overlooking the use of communicative strategies that ensure access to information regarding self-knowledge, autonomy, decision-making, and sexual enjoyment. This made the barriers to exercising their rights as sexual beings tangible in everyday life. Regarding what constitutes barriers, one participant mentions "…for people with disabilities, everything in the psychosocial sphere, all the barriers in communication" (A2M).

The way women recount their experiences with healthcare around the time they acquired a disability shows that discussing disabled bodies remains taboo. There is an omission of discourse and a separation of body from identity, and body from sexuality.

> Interviewer (I): "Did a professional approach you to explain your condition? Was there a private dialogue with you?"
>
> Participant (A2M): "No, no, no. It was a matter of… Well, let's say that diagnosis was very particular because, during the hospital rounds when someone is admitted, they start discussing the patient, and the neurologist tells their students: 'She is an 18-year-old patient, quadriplegic, etc.' When I heard them, I already knew my situation was very complex, but I didn't fully understand what was happening with my body. When I heard them, I understood… They discussed it among themselves, and that's when I realized it. But no professional sat with me to say, 'Look…' No. Maybe they did with my mom, yes. But not with me."

This illustrates that sexuality within the healthcare system is deemed insignificant. Issues related to the body beyond medical or rehabilitative practices are devalued, which suppresses the symbolic meaning of the body:

> "…Yes, sexuality is still a taboo, but beyond the taboo… it's not even because of the taboo; it's because it's made invisible, and thus not talking about sexuality becomes normalized. Do you get what I mean? It's as if, by default, this were outside the experience of a disabled woman" (A2M).

Sexuality Discourses Replicated within the Healthcare System: Professional Voices

For this section, we explored the discourses reproduced by healthcare providers regarding disabled women's sexuality. We found that this topic is minimally discussed, remaining a taboo within clinical consultations. Meanwhile, professionals might informally whisper words such as “cripple,” “lame,” “incapacitated,” “paraplegic,” “mentally retarded,” “person with difficulties,” or “handicapped" in the hallways (Responses from SD1, SD2, ED3, and CD5 in the survey). This is a topic that is neither comprehensively addressed nor discussed without stigma.

There is a noticeable indifference to the fulfillment of sexual rights. While these rights are recognized and acknowledged as discursive, social, and political concerns, they are omitted in professional practice, with attention instead directed toward reproductive aspects: family planning, gestation, childbirth, postpartum care, or pregnancy termination. The latter becomes especially prominent when disability is involved. This creates a contradiction, as discussions about the “body” are primarily framed in terms of reproductive capacities:

> I: “Do you believe the bodies of women with disabilities are different? Why?”
>
> SD1: “They have the same organs, the same reproductive physiology as a person without a disability.”

Although reproduction is emphasized, these rights are often undermined by discourses such as:

> “…then you're not really in a position to judge—a woman who develops paraplegia, and people say, 'Why did she get pregnant if she can't carry or raise the child?' That 'no'—maybe it's inside us, it's imaginary" (SD1).

Such perspectives strip disabled bodies of agency and the ability to make decisions about their sexual and reproductive desires.

A constant contradiction emerges in the practices—or, more accurately, in the avoidance of practices—and discourses of healthcare professionals. On one hand, they insist on promoting quality of life, fostering autonomy, restoring skills, or providing information. On the other hand, there is an evident inability to address or communicate issues related to one of the most comprehensive and significant aspects of human existence, particularly for women:

> “If I had to address the topic, I don’t think I would. Nor would I be interested in doing so. But that doesn’t mean I don’t recognize its validity or try to find someone who will. You know what I mean? Because I don’t feel comfortable” (SD2).

This discomfort, which leads to the violation of rights and rendering needs invisible, was particularly evident among the four female professional participants. This contrasts with the ease reflected in the narrative of the male participant, who speaks about sexuality from a position of freedom and male privilege within the patriarchal system. Even as professionals, women remain implicitly constrained by the system, uncomfortable inhabiting their bodies outside pre-established roles, contexts, and discourses.

The female participants spoke from their lived experiences, from a place of systematic silence and violence that exposes significant gaps in professional knowledge and practice:

> “As if the topic of sexuality for abled-bodied women has already been resolved. So I start from the principle that this hasn’t yet been addressed” (SD2).

In contrast, the male participant spoke of the opportunities afforded by being a man in a system designed for them, privileged with knowledge and social validation. He acknowledges that

> “(the sexuality of women with disabilities) is rarely addressed, and largely ignored. Ultimately, the patient ends up having to suffer in silence because no one talks to them about it” (CD5).

During the interviews, some discourses denied and rejected the need to consider, in all types of care, the intersections of each body, which convey symbolic meaning through individual, collective, extramural, or intramural lived experiences (outside the medical setting):

> “Honestly, there’s not even any curiosity, because you’re so focused on saving the other person’s life that, in that moment, you don’t even notice whether they have breasts or not. I mean, in those moments, the body is seen in a different context” (ED3).

This denial also emerges in academic settings. Although courses are designed to address sexuality and disability, students are not provided with the tools and knowledge necessary to meet the specific needs of this population. Instead, they replicate a normalized reproductive model:

> “There’s a course you mentioned, Physical Medicine and Rehabilitation, right? But I know the syllabus, and I know it doesn’t cover it… In fact, off the record, Dr. Pineda said it doesn’t… (laughs). But, for example, Family Medicine interns rotate in Physical Medicine for a while, and it’s the Family Medicine residents who give lectures on sexuality in disabled people, because it’s not an issue they directly address themselves” (CD5).

When discussing the functions or services provided by health professionals to their patients, we found that their discourses detached disabled bodies from essential aspects of life, ranging from individual identity and interpersonal relationships to life projects, personal and family development, and participation in social and affective life. This exclusion is reflected in actions, practices, and narratives of fragmentation, where bodies are stripped of their identity in order to be normalized and rehabilitated:

> “Because that’s what we’re here for, right? To save, to focus on functionality, to get the patient discharged early. But in terms of sexuality, I’ve certainly never done that” (ED3).

These responses reveal that disabled women face discrimination, social imaginaries, and stereotypes. According to the health professionals, they are often labeled as “asexual or hypersexual” (SD1) or subject to “the belief that they are perpetual children” (JD4).

These forms of discrimination are more common than one might expect, and lead to personal judgments that go beyond professional ethics. They stem from inexperience and from separating bodies from the real and profound needs of each woman as a sexual being, where multiple identities intersect. Infantilization appears across all types of support: during interviews, these women were often referred to as “the girls.” Although the health professionals avoided elaborating on consultation dynamics, the women highlighted discursive practices revealing how infantilization permeates care:

> I: “Have you noticed that they speak to or address your companion instead of you?”
>
> A2M: "Many times. But I'm very firm about this and always speak out. The information is for me; they should inform me directly.”
>
> I: "So, is it necessary to make that clarification?"
>
> A2M: "Of course, all the time."

We reproduce actions, communication, and information, and we communicate from hegemonic, sexist, and ableist imaginaries. At a particular stage of this research, we ourselves became subjects of study, reflecting inwardly on our own realities, trajectories as women, and professional training. This reflection made us aware of the numerous situations in which our history influences our actions and makes us generate or replicate verbal and non-verbal language that categorizes and impacts life itself.

DISCUSSION

This study focused on the discourses constructed around the sexuality of disabled women, as seen from the reality and experiences of said women, as well as by a group of health professionals working in academia. We also included our voices after engaging in a process of critical reflection. The three researchers (all women) undertook a reflective inquiry into the sexuality of this population, aiming to understand and illuminate the impact of discourses in this fundamental area of human life.

As an outcome, we realized that, as health professionals, we are part of a system that, through biopower and high-status discourses, exercises control over bodies that are not our own. Within this system, we replicate eugenic practices legitimized by medically sanitized discourses that promote the notion of an “ideal”, biologically homogenous individual, while marginalizing the rights and desires of bodies that deviate from this norm. These interventions are implicitly justified as improvements for the human population (Cruz-Pérez, 2015).

Table 2. Categories for data analysis.

Category 1. Discourses
C1.1. Sexuality Discourses Reflected in the Experiences of Women with Disabilities, From Their Own Voices
It allows us to identify how disabled women perceive their sexuality in relation to their body, pleasure, eroticism, identity, assumed roles, autonomy to decide, and other aspects, based on their lived experiences within the healthcare system.
C1.2. Sexuality Discourses Replicated within the Healthcare System: Professional Voices
It highlights the epistemological characteristics of verbal and non-verbal discourses produced and employed by health professionals, and the notions these convey about the sexuality of disabled women. Issues considered include the body, pleasure, and eroticism.
C1.3. The Role of Discourses about Disabled Women’s Sexuality
It allows us to analyze, reflect on, and interpret all collected data to examine the social conception of sexuality and its influence on the experiences of disabled women and health professionals, including the researchers themselves.

Thus, we continue to build a system that perpetuates heteronormative and ableist practices that dismiss alternative ways of experiencing sexuality, invalidating others and their ways of being or existing in the world. Despite this, sexuality is seen both as a matter involving verbal and non-verbal discursive relationships—impacting each woman's self-perception and her interactions with others—and as an individual, personal, and highly social phenomenon. Sexuality unfolds not only behind closed doors but also in public spaces such as clothing stores, hair salons, universities, and restaurants, encompassing psychological, social, biological, and cultural dimensions.

Ableism persists as a discursive and professional practice, reinforcing barriers and forms of oppression that portray disabled women as lacking, while failing to recognize them as autonomous agents capable of social interaction and decision-making regarding their own bodies.

This represents a persistent omission of responsibility. As academics and professionals, we possess the privilege that our discourses carry status, which grants power to what we say—or to what we choose not to say. This functions as an "epistemology of ignorance" (Tuana, 2006, as cited in Ruiz-Trejo & Dauder, 2018), through which we refuse to know or engage with the sexuality of disabled women so as not to disrupt our privileges or interests. Engaging with this knowledge would require discomfort, critical evaluation of what we say, from where, why, and to whom, and reflecting both inwardly and outwardly. Such critical engagement could bring forward new discursive practices that promote the exercise of sexuality in intersection with disability, gender, and other forms of oppression, beginning with addressing the gaps in academic training.

By omitting this need, the discourses that are reproduced daily create structural barriers, preventing the effective communication of requirements and information during care. This hinders disabled women from expressing their sexual demands, concerns, and desires. Consequently, comprehensive sexuality stays hidden within medical settings, extending into the social sphere, where discrimination, oppression, and patriarchal and heteronormative systems continue to intervene.

Thus, normalized healthcare services and professionals lacking communication tools to address sexuality—and the needs of both speakers and listeners on the topic—continue to expand. It is increasingly urgent to consider alternative communication strategies, where oral discourse is not the sole mechanism for creating, replicating, or transmitting information. Silence itself conveys messages, and bodies carry inscriptions of sexuality that reflect identities and life trajectories. Emotions, facial expressions, actions, or omissions often communicate more than words.

This omission has gone so far that, as women within a patriarchal system, it can be easier to avoid searching for what we want to know or express needs that are socially denied. We have been taught not to ask about our bodies, not to explore our sexuality, and to demonize pleasure and eroticism. Within this continuum of dispossession, silence, taboos, and myths, disabled women are stripped of their right to agency and decision-making.

Consequently, it is common for women to speak in whispers about "women's matters," discussing topics such as menstruation or sexual desire only among friends. This leads to the construction of non-normative identities that seek to challenge a sex/gender system rooted in normative embodiment, in which disabled women are excluded, marginalized, or rendered invisible.

> "The body is a sociocultural construct and a semiotic apparatus of representations that confers meaning: identity, value, prestige, position within kinship systems, status in the social hierarchy, etc." (Lauretis, as cited in Manada de Lobxs, 2015, p. 59).

Therefore, the needs of women's bodies should be treated as a matter of central importance. Professional support should begin with recognizing women as the owners of their bodies and acknowledging their individual desires. It should also consider the diverse ways of existing that allow women to enjoy their sexuality fully. We must abandon the pursuit of functionality grounded in normalization, which detaches disabled women from sexual identity. Instead, we should observe the body and sexuality through perspectives beyond procreation and socially imposed gender roles, aiming for a holistic perspective. The body and sexuality should be considered foundations for the personal development and identity construction of all disabled women.

CONCLUSION

The sexuality of women in general, and of disabled women in particular, is often omitted or framed by myths and infantilization, rendering it an uncomfortable topic—one best left unspoken. As a result, sexuality occupies an insubstantial position within discourses, which, through omission, become forms of systematic violence, dismissing what disabled bodies wish to communicate and experience regarding sexuality, pleasure, and eroticism.

Infantilization is a discourse that renders invisible the sociopolitical role of women within healthcare services. It negates their existence and perpetually places authority over their body in the hands of others—family members, healthcare professionals, or companions—thereby denying access to information, affection, sexual enjoyment, and physical exploration. Through the discourse of being treated as "perpetual girls," disabled women are consistently positioned under the dominion and protection of others. They are not provided with information regarding physical particularities or changes, are denied the right to make decisions about their sexual orientation, and about when, with whom, and how to have sex or access pleasure. Furthermore, they are excluded from information on family planning methods. Others assume authority over decisions regarding motherhood or pregnancy termination, reinforcing social perceptions of pity, enforced singleness, infantilized activities, and the stigmatization of desire.

Normalizing discourses and practices persist within the healthcare system, perpetuating biopolitical relations that verbally, physically, and psychologically oppress disabled women. Contemporary healthcare continues, almost immovably, to operate within a medical-rehabilitative model that pursues an ideal of the "healthy" body. Within this framework, normalizing and rehabilitative actions incapacitate and reduce disabled people to a problem that needs to be solved.

Medical or therapy appointments impact lives every day through what is said and what is left unsaid. Communication shapes, conditions, and permeates our actions as individuals and as a community; discourses construct embodied realities, especially those endowed with high status, such as the discourses produced and reproduced by health professionals. These discourses have been developed without sufficient consideration of the immense responsibility we bear, both as professionals and as individuals, in addressing women's sexuality. In practice, "other" ways of communicating, being, and existing as sexual bodies are continually relegated, directly influencing the construction and discovery of intersectional identities throughout the life course.

It is time to critically reflect inwardly on how we perceive ourselves as professionals of any gender interacting with disabled women. It is time to engage with sexuality, eroticism, and pleasure, breaking the silence and rethinking gendered roles and other assigned categories. We must understand the intersections that traverse each individual and reality by identifying, listening to, and reading the needs and desires of disabled women while considering the layers of oppression and discrimination that converge in their experience.

Sexuality encompasses a wide range of areas for intervention. While not all are addressed here, communication and sexuality are identified as critical domains that affect both us and the women we support, given the sociocultural impact of discourses surrounding these topics. This need is particularly pressing from the perspective of critical speech-language therapy, which must interrogate these discourses to rethink their signifiers and meanings. The goal is to reclaim the concept of disabled bodies and their sexuality, transforming them from abstract social categories into tangible realities.

Alternative discourses should be erected using inclusive and clear language, free from sexist, racist, classist, ableist, or heterosexist stereotypes and discrimination. Such discourses counterbalance ideologies that fragment the body, contributing to research on the communication of disabled bodies as sexual entities.

We call on academia, healthcare institutions, and health professionals to embrace new paradigms in recognizing their own bodies and sexual identities, in training, and in supporting disabled women. This includes ensuring the transmission and reception of comprehensible and accessible information for all. Healthcare practices and discourses can either perpetuate systems of oppression or serve as a pathway toward the emancipation of disabled women and their sexuality.

Let us speak openly about sex, bodies, pleasure, and eroticism, acknowledging our histories and trajectories, and taking steps toward recognizing other bodies in their diverse ways of experiencing sexuality. We must create space for dialogue, conversation, and reflection: to listen and be heard, to build alternative discourses, to inhabit rebellious bodies, and to address aspects of life that have historically been denied to us.

REFERENCES

Aponte, D. y Eslava K. (2008). Transgresiones femeninas. *Revista de Trabajo Social y Desarrollo Humano,* (13), 125-148. https://doi.org/10.25100/prts.v0i13.1180

Bejarano-Franco, M. T., Martínez-Martín, I. y Telléz-Delgado, V. (2021). Narrativas del profesorado universitario en sexualidad e igualdad. *Athenea Digital, 21*(3), e3041. https://doi.org/10.5565/rev/athenea.3041

Boccardi, F. G. (2020). Lo "sexual" y lo "reproductivo" Una genealogía de las definiciones de sexualidad en la arena discursiva internacional de los derechos. *Kairos: Revista de temas sociales*, (46), 4-33.

Bolívar, A. (2012). Metodología de la investigación biográfico-narrativa: Recogida y análisis de datos. En Passeggi, M. C. y Abrahao, M. H. (Eds.), *Dimensões epistemológicas e metodológicas da investigação (auto) biográfica* (pp. 79-109). Editoria da PUCRS.

Butler J. (2007). *El género en disputa, el feminismo y la subversión de la identidad*. Editorial Paidós Ibérica S.A.

Clos, C. y Deulofeu, G. (2022). *Sensuales: relatos de sexo y afecto en la discapacidad*. Comanegra.

Cruz-Pérez, M. P. (2015). Acceso a derechos sexuales y reproductivos de las mujeres con discapacidad: El papel de las y los prestadores de servicios. *La ventana, 5*(42), 7-45.

Ferrándiz-Armero, I. (2016). Reseña de Intersecciones: cuerpos y sexualidades en la encrucijada, de Lucas Platero [Ed.]. *Perifèria*, *21*(2), 120–129. https://doi.org/10.5565/rev/periferia.589

Ferreira, Miguel (2007, 24-26 de octubre). *Sociología de la discapacidad: Investigación compromiso*. III Congreso Nacional Discapacidad y Universidad. Zaragoza, España. https://www.um.es/discatif/TEORIA/Ferreira_Zaragoza.pdf

Foucault, M. (1971). *El orden del discurso* (A. González Troyano, Trad.). Tusquets Editores.

Foucault, M. (1999). *Los anormales*. Fondo de Cultura Económica.

Guzmán, M. y Pérez, A. (2007) La teoría de género y su principio de demarcación científica. *Cinta de Moebio, 30*, 320-333.

Herrera, F. (2021) Girls are like flowers; Boys are like footballs. *Boyhood Studies, 14* (1), 45-62. https://doi.org/10.3167/bhs.2021.140104

Jones, S., Duarte, T., Astorga, N., Pardo, M. y Sepúlveda, R. (2015). Aproximación a la experiencia de cuerpo y sexualidad de un grupo de mujeres chilenas con discapacidad física congénita. *Revista Chilena de Terapia Ocupacional*, *15*(1), 19-32. https://doi.org/10.5354/0719-5346.2015.37127

Lagarde, M. (1994). Perspectiva de género. *Diakonia*, (71), 23-29.

Lamas M. (2000). Diferencias de sexo, género y diferencia sexual. *Cuicuilco, 7*(18), 1-24.

Ludittas Sexxxuales. (2015). *Ética amatoria del deseo libertario y las afectaciones libres y alegres*. Queen Ludd.

Manada de Lobxs. (2015). *Foucault para encapuchadas*. Queen Ludd.

Marina, J. A. (2002). *El rompecabezas de la sexualidad*. Anagrama.

Musto, M. (2014). Athletes in the pool, girls and boys on deck: The contextual construction of gender in coed youth swimming. *Gender & Society*, *28*(3), 359-380. https://doi.org/10.1177/0891243213515945

Organización de las Naciones Unidas para la Educación, la Ciencia y la Cultura [UNESCO]. (2018). *Orientaciones técnicas internacionales sobre educación en sexualidad* (revisado el 12 en octubre de 2022). https://csetoolkit.unesco.org/es/toolkit/el-caso/que-es-la-educacion-integral-en-sexualidad#:~:text=La%20sexualidad%20es%20compleja%20e,2018

Organización Mundial de la Salud [OMS]. (2006). *La salud sexual y su relación con la salud reproductiva: un enfoque operativo* (revisado en octubre de 2022). https://apps.who.int/iris/bitstream/handle/10665/274656/9789243512884-spa.pdf

Organización Mundial de la Salud [OMS]. (2023) *Discapacidad. Centro de Prensa OMS* (revisado en junio de 2023). https://www.who.int/es/news-room/fact-sheets/detail/disability-and-health

Palacios-Sierra, M. y Sierra, G. (2011). Corpus para el análisis del discurso del concepto de ad hoc-cracia. En P. Cantos-Gómez y A. Sánchez-Pérez (Eds.), *A survey of corpus-based research* (pp. 386-398). Asociación Española de Lingüística del Corpus.

Platero, L. M. (2012). *Intersecciones: Cuerpos y sexualidades en la encrucijada*. Ediciones Bellaterra.

Revuelta, B. y Hernández, R. (2021). Estudios críticos en discapacidad: Aportes epistemológicos de un campo plural. *Cinta de Moebio,* (70), 17–33. https://doi.org/10.4067/s0717-554x2021000100017

Robles, B. (2011). La entrevista en profundidad: Una técnica útil dentro del campo antropofísico. *Cuicuilco*, *18*(52), 39-49.

Ruiz-Trejo, M. y Dauder, G. (2018). Los talleres "epistémico-corporales" como herramientas reflexivas sobre la práctica etnográfica. *Universitas Humanística*, (86), 55-82. https://doi.org/10.11144/Javierana.uh86.tech