

Pregnancy in Women With Physical Disabilities

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■ Women with disabilities are growing in number and increasingly interested in becoming mothers and raising children. However, health care providers are often unfamiliar with the health care needs of this group of women and overlook the important issues that make the difference between positive and negative experiences of these women. This article describes the preconception, antenatal, pregnancy, and postpartum issues of women with disabilities and suggests approaches to ensuring that women with disabilities have successful reproductive experiences. *JOGNN*, 36, 88-96; 2007. DOI: 10.1111/J.1552-6909.2006.00121.x

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Between 54 and 60 million people in the United States are estimated to have disabilities, and more than half of them are women (U.S. Census Bureau, 2003). Women with disabilities who are pregnant or are considering pregnancy and childbearing often experience negative reactions to the idea of their becoming parents from family members, health care providers, and society as a whole (Earle & Church, 2004; Lipson & Rogers, 2000). They are often stereotyped as not “normal” and their legitimate right to becoming parents is often questioned.

Women with disabilities experience the same fears and uncertainties experienced by all women considering pregnancy, but their concerns are often compounded because of their disabilities (Rogers, 2006; Smeltzer, 2002). A woman with a disability may ask herself: Will I be able to become pregnant and carry the pregnancy to term? Will I be able to undergo labor

and delivery safely? Will my pregnancy affect my disability and my disability my pregnancy? Will I be able to adequately care for an infant and be a good mother as my child grows and develops despite my disability? Will someone try to take my child away because I have a disability (Carty, 1998; Rogers; Smeltzer)?

Disability is defined as a consequence of impairments, activity limitations, participation restrictions, and environmental factors (World Health Organization, 2001). In 2001, the World Health Organization revised its definition of disability from a *disease* focus to one that focuses on *health*. This change in focus is key when considering pregnancy in women with disabilities. In a biopsychosocial model of disability, providers recognize that women with disabilities are knowledgeable about their disabilities, full partners in decision making, and the experts on how their bodies respond because they live with their disabilities on a daily basis and have experienced disability first hand (United States Public Health Service [USPHS], 2005).

The effectiveness of nurses and other health care providers in addressing pregnancy and childbearing in women with disabilities will depend in part on (a) their views and perceptions about disability and childbearing in women with disabilities, (b) their understanding of the effects of the disabling condition, (c) the perceptions of women with disabilities about themselves and their desire to become parents, and (e) women’s need for, access to, and use of resources that will enable them to have a healthy pregnancy, safe labor and delivery, and smooth postpartum period. This article discusses physical and psychosocial issues encountered by women with disability during pregnancy and the health and well-being of women with disabilities from preconception through the postpartum period.

Communicating With Women With Disabilities About Pregnancy and Childbearing

Some women with disabilities, particularly those with developmental disabilities or disabilities acquired early in life, have been excluded from discussions about sex and reproduction during their school years (Smeltzer, Sharts-Hopko, Ott, Duffin, Zimmerman, & Duffin, in press). Further, they are often considered asexual by health care providers who fail to discuss safer sex, contraception, pregnancy, and gynecologic care with them (Basson, 1998; Earle & Church, 2004). As a result, they may lack basic information about reproductive function and pregnancy. Thus, it is important for clinicians to listen carefully to women's views and questions, to assess their desire and need for information. Because of stereotyping and their fears that they will appear incapable of caring for themselves or others, women with disabilities may be reluctant to ask questions or to ask for assistance (Campion, 1997).

While it is important to avoid focusing on a woman's disability to the exclusion of other issues related to pregnancy and childbearing, it is equally important not to ignore the disability and modifications that may be needed to provide appropriate care. Attention to the concerns and information needs of women with disabilities and to potential health issues related to the disability is essential in caring for women with disabilities to ensure a healthy pregnancy and a healthy baby.

Although important for all women, care and communication must be empowering and must focus on women's abilities rather than disabilities. Communication that suggests that a woman is incompetent will lead to self-doubt and lack of confidence on her part. Many women with disabilities have been successful in becoming pregnant, delivering healthy infants, and caring for them without any impact of the disability. Others have been very successful, loving parents but need support and assistance to enable them to be successful mothers. They have been very successful, despite encounters with clinicians who have tried to discourage them from considering pregnancy because of their bias that women with disabilities are ill equipped to be good parents (Lipson & Rogers, 2000; Thomas & Curtis, 1997). Because many women with disabilities have been very successful mothers, it is important not to assume that they are unable to parent well.

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Women with disabilities should be encouraged early in their pregnancies to begin to identify supports, assistance, and modifications that may be needed to enable them to care for their babies, but without conveying the message that they are unable to care for their children. If a woman has a communication impairment (e.g., deaf, hard of hearing, impaired speech or uses a communication board), modifications must be made to enable two-way communication between the woman and her health care providers. Writing, speech/lip reading, use of assistive hearing devices or a sign-language interpreter are examples of strategies to promote effective communication. Women should be asked the method of communication they prefer and accommodations made available for all interactions with them.

Preconception Issues

The health care provider needs to avoid suggesting directly or indirectly that the woman with a disability who is seeking preconception counseling is unfit and irresponsible for considering childbearing. Further, it is important that health care providers realize that women with disabilities may be very uncomfortable or even offended if prenatal testing is offered. The suggestion for prenatal testing may have a negative connotation to women with disabilities who may perceive such testing as a first step to trying to eliminate persons like themselves, that is, persons with disabilities (Rogers, 2006; Scott, 2005).

Women with disabilities should receive preconception counseling to make sure that they are in the healthiest condition possible. Emphasis should be on nutritional status, weight control, cessation of smoking and alcohol use, and treatment of any active symptoms or secondary conditions related to the disability (Misra, Grason, & Weisman, 2000). Because many women with disabilities take medications for treatment of disability-related disorders (McCarter-Spaulding, 2005), they are advised to review these with their health care providers, so medications with a teratogenic potential (e.g., disease-modifying agents, anti-convulsants, immunosuppressive agents) can be modified or stopped before pregnancy is attempted. Preconception discussions with women whose disabling conditions necessitate the use of medications for treatment of relapses, complications, or disability-related symptoms may prevent unexpected dilemmas during pregnancy, when women may have to make difficult decisions about taking medications that have the potential to affect the health of the fetus (Misra et al.).

Daily consumption of folic acid (400 mg) prior to conception is as important for women with disabilities as it is for other women. If the woman had a previous pregnancy affected by neural tube defect, has spina bifida, or takes anticonvulsants, increasing the folic acid dosage to 4 mg (4000 µg) for 1 month prior to attempting pregnancy and

during the first 3 months of pregnancy is recommended (Norwitz & Repke, 2005).

Prenatal Issues

Many women with disabilities that affect their mobility have reported barriers to health care because of lack of access to health care providers and health care facilities and offices (Coyle & Santiago, 2002; Nosek, Howland, Rintala, Young, & Chanpong, 1997). Barriers can include negative attitudes on the part of health care providers as well as barriers to physical access, including lack of accessible parking, narrow doorways, lack of an adjustable examination table, inaccessible bathrooms, and inadequate assistance during the health care visit. Because these barriers may prevent women with disabilities from obtaining health care during pregnancy, efforts need to be made to assess and improve accessibility before a need arises, so that pregnant women with disabilities can receive care in a comfortable and dignified manner.

Barriers to care can include negative attitudes on the part of health care providers as well as lack of physical access.

When a woman with a disability first seeks prenatal care, it is important not to assume that she wants to terminate the pregnancy. Women with disabilities have reported being offered immediate termination of pregnancy based on the assumption that they do not want to be pregnant or should not be having children (Carty, 1998). Women are likely to find this suggestion objectionable; rather, they should be assessed about their reactions to pregnancy in the same way that other women might be assessed about their feelings about pregnancy, plans for prenatal care, labor and delivery, and postpartum care.

The prenatal care of many women with disabilities usually does not differ dramatically from that of women without disabilities, and many women with disabilities are not considered high risk when pregnant. Some women's disabilities do, however, increase their risks, and some health issues may require special consideration even if women do not fit high-risk criteria. Some health issues are more commonly associated with specific types of disabilities (see Table 1), and other issues pertain to most women regardless of the type of disability.

In addition to the typical history performed at the first prenatal visit, the history should focus on (a) the woman's general health status, (b) nature of the disabling condition, (c) medications used to treat the disabling condition or

secondary conditions related to it, and (d) her concerns related to the interaction of pregnancy and the disabling condition. Although it is important for the clinician to understand the limitations on usual function and activities of daily living, these need to be assessed with care to avoid interrogating the woman so that she feels that her ability to care for herself and children is being questioned. Discussion during this initial prenatal visit should also address disability management issues that may affect the pregnancy. Efforts to collaborate with the woman's primary health care provider or disability specialist should be initiated. Consultation with a physiatrist may be helpful for women whose disabilities affect ambulation and sitting, to be certain that appropriate assistive devices and seating modifications are made to accommodate women's changing bodies during pregnancy (Welner & Temple, 2004).

Because of the increased incidence of abuse during pregnancy, coupled with the high risk of abuse of women with disabilities (Nosek, Howland, & Young, 1997; Young et al., 1997), it is also important to assess women for abuse. The Abuse Assessment Screen-Disability (McFarlane, 2001, Young et al. (1997) is easy to use and addresses the diverse types of abuse experienced by women with disabilities.

Many women with disabilities, especially those with developmental and cognitive disabilities, receive gynecologic care and examinations less often than women without disabilities (Coyle & Santiago, 2002; Thierry & Cyril, 2004); therefore, the clinician should not assume that all women with disabilities understand the purpose of the physical examination and know what to expect and what is expected of them. If a woman has not had pelvic examinations in the past and is fearful or has been sexually abused in the past, the examiner must build trust with her, be patient, and allow her to guide the examination. She needs to be comfortable with the clinician who is doing the examination and feel that she is in control of what happens to her.

It is important to explain throughout the examination what is being done and what sensations the patient may feel. The clinician should not assume that all women with similar disabilities are the same and have the same sensations. Women with multiple sclerosis and spinal cord injury who experienced pain or discomfort during procedures have reported being told that they cannot possibly be experiencing pain or discomfort because of the nature of their disabilities. It is important to ask the woman what she is sensing throughout the examination.

An adjustable examination table makes it possible for a woman with a disability to safely and relatively easily transfer or be transferred from a wheelchair to the table and back. While more costly than nonadjustable tables, these tables make obstetric and gynecologic care easier for both women and clinicians (Welner & Temple, 2004). All women should be asked what assistance they require to get

TABLE 1
Care for Problems Arising From Disabilities in Pregnancy

<i>Problem</i>	<i>Disabling Conditions</i>	<i>Description</i>	<i>Implications for Care</i>
Autonomic dysreflexia (autonomic hyperreflexia)	Spinal cord injury, especially with lesions above T10, especially lesions at or above T6	Activation of the sympathetic nervous system can be triggered by uterine contractions, oxytocin, UTI, distention of the bladder, constipation or fecal impaction, ectopic pregnancy, pelvic or rectal examination, pressure ulcers. Early signs and symptoms include headache, sweating and piloerection above the level of the spinal lesion, nasal stuffiness, and facial flushing. Severe signs include hypertension, irregular cardiac rate, facial flushing, shortness of breath, increased muscle spasticity. May stress the fetus. Serious complications include seizures, intracranial hemorrhage, coma, and maternal death (Norwitz & Repke, 2005)	Women with SCI should be assessed for signs and for factors that can precipitate AD (full bladder or bowel, pelvic examination, labor). Pelvic examination should be performed when others are available to assist in case AD occurs and with patient's head elevated as high as possible. If history of severe AD, pelvic examinations should be performed only when emergency assistance is readily available. Anesthetic gel applied to the vagina and speculum may reduce risk of AD (Madorsky, 1995). If AD occurs, the exam should be halted immediately, the head of the bed raised, and rapid-acting antihypertensive agents such as nifedipine administered. In labor, epidural anesthesia can prevent AD (Norwitz & Repke, 2005). If AD occurs, prompt delivery of the baby and placenta is essential
Deep vein thrombosis	Disabilities that limit mobility; wheelchair users	Venous stasis and pressure of the growing fetus prevent venous return from the legs and increase the risk of deep vein thrombosis (Baschat & Weiner, 2004)	The lower extremities should be assessed for warmth, redness, edema, or asymmetry. Elastic compression stockings and elevation of lower extremities are useful, especially in late pregnancy, to promote venous return
Latex allergy	Spina bifida	Allergic reactions may cause relatively mild symptoms (erythema and pruritus) or may rapidly progress to anaphylactic reaction (i.e., urticaria, wheezing, dyspnea, laryngeal edema, bronchospasm, tachycardia, angioedema, hypotension, and cardiac arrest)	Women should be screened for latex allergy, especially those with spina bifida and a history of repeated surgeries. Gloves and all items (e.g., urinary catheters, IV lines) must be assessed for latex before use. Antihistamines and epinephrine must be readily available
Urinary tract infections	Neurologic disorders (e.g., spina bifida, MS, SCI, cerebral palsy)	Many disabilities increase risk for UTI; risk increases during pregnancy, especially in women with neurogenic bladders (Donaldson, 2005). During pregnancy, UTIs are more likely to ascend to the kidneys and cause pyelonephritis, premature onset of labor, and fetal mortality (Foxman, 2002). Infected pressure ulcers increase the risk for UTI	Increased fluid intake is recommended along with use of vitamin C, cranberry juice or cranberry extract tablets to decrease the urine pH and prevent adhesion of bacteria to the uroepithelium (Howell & Foxman, 2002; Smeltzer & Sharts-Hopko, 2005). Probiotic therapy helps restore normal vaginal flora and may prevent UTI (Stapleton, 2003)

(continued)

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Urinary incontinence	Neurologic disorders (e.g., spina bifida, MS, SCI, cerebral palsy)	Urinary incontinence may increase in pregnancy in women with preexisting bladder dysfunction because of the pressure of the growing fetus (Madorsky, 1995)	A bladder management program should be implemented if not in place and evaluated if urinary incontinence increases
Compromised respiratory function	Neurologic disorders (e.g., high cervical or thoracic SCI, myasthenia); cystic fibrosis	The diaphragm is elevated and chest configuration altered during the second half of pregnancy (Donaldson, 2005). Preexisting respiratory dysfunction can worsen during late pregnancy and labor. Ventilatory support may be required (Madorsky, 1995; Norwitz & Repke, 2005)	Respiratory function should be monitored in women whose disability affects thoracic excursion. Availability of ventilatory support is essential in women at high risk
Spasticity	Neurologic disorders (i.e., spina bifida, MS, SCI, cerebral palsy)	Spasticity (increased muscle tone and resistance to passive movement) is often more pronounced at the extremes of range of motion. It is increased by pain, a cold room, contact with a cold speculum, stress, and rapid movement	Women with spasticity should be moved slowly and gently. Alternate positions for the pelvic examination may reduce risk of spasticity. Lidocaine applied to the perineum may reduce discomfort and risk of spasticity (Welner & Temple, 2004). To avoid falls, women who have spasms or spasticity should not be left alone on examination tables
Risk of pressure ulcers	Neurologic disorders characterized by impaired sensation (e.g., SCI, MS)	Pressure points may change during pregnancy as weight and body distribution change. Risk for pressure ulcers may be increased in women with anemia	Skin and bony prominences should be assessed frequently in women with impaired sensation. Women should be taught to assess their skin and change positions to prevent skin breakdown. Anemia should be prevented through adequate iron intake (Carty, 1998; Norwitz & Repke, 2005)
Constipation	Neurologic disorders characterized by neurogenic bowel problems (e.g., SCI, MS)	Supplemental iron may cause severe constipation during pregnancy in women with preexisting neurogenic bowel problems	Nutritional modifications, increased fluid intake, cautious use of iron, and stool softeners are indicated to prevent severe constipation
Unrecognized onset of labor	Disabling conditions characterized by impaired sensation (e.g., SCI, spina bifida)	Unrecognized onset of labor may result in premature or unassisted delivery, increasing risks to baby and mother. Women with spasticity may be more aware of the onset of contractions because of increased spasms and spasticity (Baschat & Weiner, 2004)	Weekly cervical examinations after 28 weeks' gestation are recommended to detect premature labor. Uterine activity monitoring may be used. Women should be instructed to perform abdominal palpation and report changes that may indicate contractions (Norwitz & Repke, 2005). Bed rest may be prescribed if labor begins early

(continued)

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Severe fatigue	Disabling conditions including MS, RA, SLE, fibromyalgia)	The fatigue common in pregnancy may be increased in women whose disabling conditions have fatigue as a major characteristic	Fatigue may be especially severe during the first trimester. If it is incapacitating, women should be evaluated for treatable causes. Women can be advised to take scheduled rest periods during pregnancy and the postpartum period, use energy-saving strategies, and balance rest with exercise within the limits of their disabilities
Increased symptoms or worsened disability during pregnancy	Systemic lupus erythematosus	Due to changes in immune status that characterize pregnancy, disorders characterized by autoantibody production (e.g., SLE) tend to worsen during pregnancy, and risk of pregnancy loss is increased (Silver & Branch, 1997)	Women whose SLE worsens during pregnancy are at increased risk for hypertension and premature delivery; thus, they should be monitored closely by a clinician skilled in managing women in this high-risk category
Increased symptoms or worsened disability after childbirth	Multiple sclerosis, RA	Immune-mediated disorders that are cell mediated (MS, RA) tend to improve during pregnancy but tend to worsen in the postpartum period (Silver & Branch, 1997)	Symptoms may be stable or decreased during pregnancy but flare up during the postpartum period. Women should be informed about this possibility and monitored following delivery. Disease-modifying medications should be resumed and significant flares or exacerbations treated
Falls	Conditions with impaired balance or coordination, muscle weakness, or paralysis (e.g., MS, SCI, spina bifida, cerebral palsy)	Change of the woman's center of gravity late in pregnancy due to expanding uterus combined with impaired balance and lack of coordination due to disability increase the risk for falls (Rogers, 2006)	Women at risk for falls should be encouraged to use assistive devices (canes, walkers, or wheelchair) to prevent falls and fractures (Welner & Temple, 2004)

Note. AD = autonomic dysreflexia; SCI = spinal cord injury; UTI = urinary tract infections; MS = multiple sclerosis; RA = rheumatoid arthritis; SLE = systemic lupus erythematosus.

ready for the examination and to move to the examination table. The woman rather than the clinician or staff should direct the process of transferring and changing positions.

Alternate positions for pelvic examinations may be necessary for the comfort of the patient or if she is unable to assume the traditional lithotomy position. Prior to examination, it is important to assess the woman for spasticity or contractures that require special maneuvers to enable the clinician to complete the pelvic examination. *Table Manners and Beyond* (<http://www.bhawd.org>) is an excellent resource for various positions that may be used for pelvic examination of women with disabilities, as well as other guidelines for providing health care for women with disabilities.

Other monitoring that is part of routine obstetric care may also require modification if the woman has a disability. While monitoring of weight throughout pregnancy is routine for most women, many women who are wheelchair users have reported never being weighed during pregnancy (Lipson & Rogers, 2000). Clinics should consider obtaining a scale that enables women to be weighed while in their wheelchairs. If a woman is unable to be weighed or fundal height accurately measured, periodic ultrasounds can provide information about the size of the growing fetus.

Some women may have difficulty providing urine specimens because of physical limitations related to their

disabilities or limited space in the bathroom of the office or clinic. They may need to perform self-catheterization if they do this routinely or be catheterized in order to obtain a specimen. Alternatively, arrangements may be made in advance for them to bring a urine specimen to their appointment, to ensure that they are monitored throughout pregnancy with the same attention as other women (Rogers, 2006).

Depending on the nature of their disabilities, some women may experience an increase in symptoms or an exacerbation of their underlying disabling disease during pregnancy. Although it is preferable to discuss medications to treat these symptoms prior to conception, discussion of risks and benefits of treatment when symptoms or exacerbations appear during pregnancy is also warranted. Medications commonly required include antibiotic therapy for the treatment of urinary tract infections (UTIs). The incidence of UTIs is increased in women with disabilities even without pregnancy, and the risk is even higher during pregnancy, especially in women with neurogenic bladders associated with neurologic and musculoskeletal disorders (Donaldson, 2005). Untreated UTIs may precipitate autonomic dysreflexia (AD; hyperreflexia) (see Table 1) in women with spinal cord injury and may result in uterine contractions early in pregnancy. Frequent monitoring for UTIs is recommended. Prophylactic antibiotics or urinary antiseptics may be warranted in women with recurrent UTIs or history of pyelonephritis (Baschat & Weiner, 2004).

Labor and Delivery

Similar to other women, those with disability are often anxious and concerned about labor and delivery; additional concerns, however, arise because of the presence of a disability. Women with disabilities have reported that a decision about type of delivery was made arbitrarily without consulting them or considering the possibility of being able to deliver vaginally (Campion, 1997; Lipson & Rogers, 2000). Many women are concerned that they will be forced to have a caesarean birth simply because they have disabilities.

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Although there are circumstances in which caesarean delivery is warranted for the safety and well-being of the

woman and her baby, these decisions should be based on sound obstetric indications rather than the mere presence of a disability. Women are often able to identify what they will and will not likely be able to do during labor and delivery. For example, if a woman is able to generate adequate abdominal pressure for effective urinary and bowel management, she is more likely to be able to assist during delivery.

Anesthesia during labor and delivery is another concern for many women with disabilities. Most women with disabilities are able to safely undergo the same anesthesia as other women, although risks of AD in women with spinal cord injury and of spinal anesthesia in women with multiple sclerosis should be taken into account (Sevarino, 2004). Consulting with the anesthesia provider during the prenatal period and formulating a plan are recommended.

Postpartum Period

Prolonged recovery from the birth experience, child care, and risks associated with their specific disability may occur. Women with disabilities may require a longer period of time and longer hospital stay to recover from vaginal delivery or caesarean section. The hospital room and bathroom should be made as accessible as possible and enable the woman to have easy access to her infant (Carty, 1998; Madorsky, 1995). Women whose level of mobility has decreased because of physical changes associated with pregnancy may benefit from consultation with a physiatrist or physical therapist to identify an exercise program that will return them to their prepregnancy function.

As with other women, breastfeeding is encouraged, although women with disabilities, especially those that affect their upper extremities, may initially require assistance and guidance to identify positions and adaptive strategies that allow them to hold the baby to the breast comfortably. Adaptive strategies for child care include creative use of pillows to support the mother and baby for breastfeeding when in a wheelchair, handles attached to baby bottles for women with weak hand grasp, and adjustable height feeding chairs. Cribs that can be opened from the side, low dressing tables, and a side car attached to the mother's wheelchair will make it easier for women with disabilities to be as independent as possible in caring for their infants (Rogers, 2006).

An occupational therapist can be invaluable in identifying assistive devices that can be used or modified for self-care and infant care (Farber, 2000; Lipson & Rogers, 2000). A home assessment may be useful in identifying home modifications. These modifications might include having the baby's bassinet or crib in the woman's bedroom to enable her to care for and comfort the infant without having to go into another room to do so, which may be difficult for some women with disabilities. Health care providers should become familiar with the contributions

that occupational and physical therapists can make to the independence of women with disabilities during pregnancy and in child care.

The needs of women following delivery will vary, based on changes that have occurred during pregnancy and their risk of increased symptoms or disability during the postpartum period. Some cell-mediated immune disorders (e.g., rheumatoid arthritis and multiple sclerosis) tend to be more quiescent during pregnancy and to flare during the postpartum period, while other immune disorders (e.g., systemic lupus erythematosus) may worsen during pregnancy (Silver & Branch, 1997). Women whose disease-modifying medications were halted during or before pregnancy are often encouraged to resume therapy soon after delivery, to prevent symptoms and increased disability. Breastfeeding may be contraindicated once disease-modifying therapy is resumed.

Negative responses from others because of bias and stereotyping extend into the postpartum period. Women may benefit from participation in parent groups with mothers with disabilities as well as without disabilities. Women who are confident about their ability to mother are more able to respond to questions from those who have never before encountered a disabled mother with a young baby. A clinician who serves as a sounding board and helps to identify resources may be helpful in bolstering women's confidence in their own parenting skills. Further, clinicians can direct women to support groups or even consider starting support groups for women with disabilities, to enable them to obtain support and share successes with other women (Harrison & Stuifbergen, 2002).

Childbirth and Child Care Education

Childbirth education material and classes should be examined to determine whether they are accessible to women with disabilities and the information is appropriate and specific to their unique concerns. Women with disabilities have reported that standard information is rarely tailored to them and is often a waste of time (Blackford, Richardson, & Grieve, 2000; Lipson & Rogers, 2000). Childbirth education that ignores or limits discussion of the concerns and questions of women with disabilities may result in high anxiety levels and loss of potential support and role modeling from other women with similar concerns and questions (Lipson & Rogers).

Spouses and families can benefit from individualized prenatal education about child care to learn how to assist new mothers in caring for their new babies within the context of disability. Professionals should not assume, however, that the woman will be unable to provide care for her baby and that others will be responsible for caring for the baby. Family members may have negative reactions and questions about the ability of women with disabilities to manage care of their babies. Discussing and demonstrating

adaptations in child care with the woman and her family may provide role modeling and promote understanding and acceptance by family members.

Resources and services that address the needs of women with disabilities should be identified and provided. *The Disabled Woman's Guide to Pregnancy and Birth* (Rogers, 2006) is an excellent resource for women and provides information for women from preconception to postpartum period and care of an infant. When a health agency has educational materials in alternate formats (large type, audiotapes, picture format, etc.), the information is not only accessible and useful to women with disabilities but will also convey to women, their families, and others that pregnancy and childbearing are normal in the lives of women, regardless of their disabilities. *Through the Looking Glass* (www.lookingglass.org) is an on-line resource that provides accessible information about parenting by people with a variety of disabilities.

Summary and Conclusion

The number of women with disabilities is increasing and many have the same desire as other women to become parents. However, negative attitudes and bias against childbearing and parenting by women with disabilities, inadequate knowledge about their health care needs, and lack of attention to the issues and concerns of women with disabilities have made the process difficult for many of them.

Nurses aim to be holistic in their approach to the patients in their care. Thus, women with disabilities who are pregnant or considering pregnancy should be able to expect that the holistic approach extends to them, and that clinicians will welcome their legitimate claim to be parents and provide care and support them through their pregnancies.

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