

International Encyclopedia of Rehabilitation

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Pregnancy Planning for Women with Mobility Disabilities

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It is still surprising to many people without disabilities when a person who has a disability becomes a parent. However, more people with disabilities are now considering and pursuing parenthood. As part of her decision making of whether to become pregnant, a woman with a disability may want information on if pregnancy will have a deleterious effect on her. Unfortunately, she may have difficulty finding any information on the subject. There are a number of reasons that finding this type of information is difficult.

One of the reasons is how disability is taught in medical school. As the American College of Obstetrician and Gynecologist (2005) observed, “Few health care professionals have received comprehensive information about caring for individuals with disabilities in their medical schools or training programs.” Generally, physical disability is taught as a separate self-contained entity rather than incorporated throughout all segments of medical education. The result is that the interaction between having a pre-existing physical disability and any other medical issue (e.g., cancer and pregnancy) does not appear to be taught in medical schools in the United States. Therefore, physicians may not have knowledge about how pregnancy and birth affect a woman with a physical disability. In addition, it is difficult for a majority of physicians to know how to manage the impact of pregnancy. Moreover, the woman may be the first woman with a disability in that obstetrician’s (OB’s) practice. Since the number of pregnant women with disabilities is still low, a pregnant woman with a disability will rarely find a practitioner who has any knowledge of the interactions of her specific disability and pregnancy.

Another reason is lack of training during residency and exposure to people with disabilities among practitioners. For example, in the 18th edition of Williams Obstetrics (Cunningham et al. 1989), considered the authoritative book on obstetrics, there was no mention of pregnant women having any physical disability. In the 21st edition, (Cunningham et al. 2001) published 12 years later, several disabilities were mentioned. However, the types of disabilities discussed were those generally acquired after childhood (e.g., spinal cord injuries and multiple sclerosis). Congenital disabilities only were discussed in regards to the delivery of a baby who had that condition/disability and not with regards to the mother with the same condition/disability.

The consequence of lack of medical education around the complexity of disabilities is the lack of research on the subject. The American College of Obstetricians and Gynecologists (2005) observed that there has been little research on health care for women disabilities.

Likewise, there is very little hard evidence resulting from research concerning pregnancy and disability. Research studies on pregnant women with acquired disabilities far outnumber the number of studies concerning women with congenital disabilities. Even though there are a few

studies available, these studies have inherent problems. As Rogers (1998) observed, “Most reports consist of an individual physician's account of a single pregnancy with a disabled mother, or anecdotal reports by disabled mothers of their non-medical perceptions of pregnancy. These personal anecdotal records are often of first pregnancies. Some studies are retrospective, with the inherent problems of accurate recall.”

A difficulty in doing research on pregnancy and disability is the low incidence of pregnant women who possess the same disability. It can take several years to find enough women to get a sufficiently large research sample. Dr. Amie Jackson (1996) found that recruiting 474 women with spinal cord injuries to participate in one study required the collaboration of 10 regional spinal cord injury centers over a period of three years. Jackson studied pre- and post-injury pregnancies and compared the differences. However, in this study of 474 women, only 66 women (14%) had 101 combined post-injury pregnancies.

Since there is a dearth of research, some physicians may make false assumptions on treatment options for pregnant women with disabilities. For example, many physicians believe that women with disabilities cannot deliver vaginally. (See section on birthing)

Much of the material for this paper was provided from two sources: 1) information gathered in the writing of *The Disabled Woman's Guide to Pregnancy and Birth* (Rogers 2005); and 2) information obtained from providing consultation and technical assistance to thousands of women who called seeking information on pregnancy, birthing, and parenting from Through the Looking Glass.

Through the Looking Glass (TLG) is the National Center for Parents with Disabilities and their Families. Founded in 1982 in Berkeley, California, TLG emerged from the independent living movement. TLG is a nationally recognized center that has pioneered research, training, and services for families in which a family member has a disability or medical issue.

From both research for the book and these ongoing consultations at TLG, a common misconception arose that a woman with a disability will have her condition worsen because of pregnancy. In fact, some women with certain disabilities such as multiple sclerosis and rheumatoid arthritis will probably experience a remission in their symptoms during pregnancy (Confavreux 1998; Ostensen, 1991, respectively). Additionally, some women with a disability have found that their decubiti (i.e., pressure sores) and other skin conditions improve during pregnancy. One interviewee for *The Disabled Woman's Guide to Pregnancy and Birth* (Rogers 2005) who had spina bifida found that pregnancy “was the first time in her life that her decubitus on her foot healed.” However, not all women have a problem free pregnancy. Although all women, regardless of disability may experience complications with their pregnancy, “some health issues are more commonly associated with specific types of disabilities” (Smeltzer 2007). A woman with a disability may want to take her needs into account when planning for pregnancy, birth, and motherhood. Overall, it is a good idea that the woman become as healthy as possible prior to pregnancy such as stopping smoking, getting physically fit (as appropriate for her disability), and eating according to sound nutritional guidelines as they relate to her specific disability (e.g., women with spina bifida will need more folic acid than is recommended for other women, etc.).

Before Conceiving

Visit your disability specialist

If a woman is on medication(s), she will need to talk to her doctor about taking medication during pregnancy as well as planning for treatment after childbirth. Depending on which drugs a woman is taking, she may need to stop taking medication or change medication several months before getting pregnant. It is important to check all the medications because some are safe for the fetus, while others may not be.

Getting More Medical Information

When consulting with an OB on becoming pregnant, it is important to discuss what information the OB has found in the literature on pregnancy and disability and the reliability and validity of that research. Women with certain disabilities will need to know how good their pulmonary, kidney, and heart organ functions are because pregnancy can negatively impact those organ functions (American College of Obstetricians and Gynecologists 2002). This is often overlooked by the women themselves. For example, some callers to TLG with spina bifida inquiring about the impact of pregnancy were concerned about possible mobility issues but unaware of the potential impact of pregnancy on their kidney function, which has a more detrimental effect on their overall health. Since during obstetrics residency physicians do not get training about disabilities, they can make inaccurate assumptions. As Smeltzer (2007) stated, “The clinician should not assume that all women with similar disabilities are the same and have the same sensations. It is important to ask the woman what she is sensing throughout the exam.” The experience of an interviewee for the *The Disabled Woman’s Guide to Pregnancy and Birth* (2005) who has a spinal cord injury resulting in quadriplegia illustrates the importance of good communication between patient and healthcare provider. This interviewee did not specifically inform her physician that she had sensation in her perineum area and nor did he ask. The physician proceeded to repair the episiotomy and suture the area without anesthesia, assuming the woman was not able to experience pain. Ultimately, she needed to call out to the physician to stop suturing due to pain.

Anesthesiologist

See birthing section.

Finding the right obstetrician (OB)

It is important to begin the search for an obstetrician as soon as possible. For some women, they have to interview several obstetricians until they find one who is supportive and positive about the pregnancy. Women with certain disabilities often feel they had the best obstetric care when they were referred to an obstetrician from their disability specialist. Often this can mean that the OB and the disability specialist regularly consult with one another during the pregnancy. It is important for the woman to know all the on-call physicians working with the OB since there is no guarantee which physician will be available to deliver the baby. It is prudent for the woman to ensure that all on-call physicians (or partners) are knowledgeable about her specific disability needs. In addition, ensuring that the physician is knowledgeable about delivering vaginally can prevent the woman from having an unnecessary Cesarean section (C-section). (See birthing section)

Accessibility of OB Office

If a woman uses a wheelchair, she will already know whether her doctor's office and its bathrooms are wheelchair accessible. But those who generally do not need any accommodation may find that they need grab bars in the bathroom when pregnant and are unaware if their doctor's office is accessible. Title III of the Americans with Disabilities Act (the ADA) (1990) covers accessibility in a physician's office. If there is not an undue burden on a physician's practice, women who have disabilities are entitled to reasonable accommodation in their doctor's office such as having an accessible exam table. If the practice is for profit and buys an accessible exam table, they could be eligible for a tax credit. "Health care professionals need to know that physical barriers, such as accessible scales or examination tables, present enormous and recurring obstacles to obtaining adequate prenatal care" (Thierry 2006). Being weighed is a necessary part of the exam, but it can be difficult for women who are disabled. If the office does not have an accessible scale, the woman can use a scale at a nursing home or rehabilitation unit. There are several accessible scales available to purchase.

Preparing for Parenting

For some prospective parents, the need to find an occupational therapist (OT) who can help with solutions for baby care tasks will be important. Going to an OT and a physical therapist to get in better physical shape prior to delivery can help prepare the mother for many baby care activities such as learning to transfer the baby. If the mother goes early in her pregnancy, it will be better because she will not have to cope with the physical changes to her body caused by the pregnancy while learning new tasks. The occupational therapist can provide techniques for baby care tasks such as diapering one handed and with designs for appropriate baby care equipment. Having appropriate baby care equipment and knowledge of baby care techniques can mean the difference between "being an observer" and an active participant in parenting. It is, therefore, important to find equipment that would allow the mother to hold, feed, and play with the baby to foster attachment. Without equipment, many parents are able to care for their child, but they put themselves at risk for secondary injury in trying to ensure the safety of their child as was documented in research by Through the Looking Glass (1995) examining the impact of equipment on baby care activities.

For some baby care equipment, it will be necessary to have either a rehabilitation or mechanical engineer involved. It can sometimes be challenging to find someone who has the skills to design and fabricate needed adaptive equipment so going to a local engineering department at a university can be a good solution. Working with an occupational therapist can not only build a mother's confidence in her ability to take care of the baby but also empower the mother to address any concerns hospital staff may have about her ability to effectively care for her baby and ultimately alleviate their fears. Because equipment needs are prescribed by function and not disability, it can be difficult to catalogue all the different types of baby care equipment that may be appropriate for the unique needs of an individual parent. So, a mother should consult with an OT to identify equipment that will allow her the maximum independence in carrying for her baby.

Insemination

Some women may need insemination because of their partner's disability or having a same sex partner. Other women may choose insemination because they have no partner and desire a baby.

Case Study

Carol (a pseudonym) who has quadriplegia cerebral palsy (CP), contacted TLG because she wanted to explore insemination. She also wanted to talk with someone else who had insemination. Carol had gathered information and decided to see a fertility specialist. A doctor told Carol he was willing to do it and that he has had patients who have a spinal cord injury, but not CP. He told Carol that she needed to get a medical clearance for high-risk pregnancy. The specialist did not question whether cerebral palsy would inherently cause a high-risk profile. Unlike high spinal cord injury, CP does not have any aspects that would cause a rise in blood pressure. In researching women who have cerebral palsy, there was no evidence associated with cerebral palsy and high risk. There are some conditions which would cause a high-risk pregnancy such as heart disease, kidney problems, autoimmune disorders, sexually transmitted diseases, diabetes and cancer (Cunningham 2001). Sending someone to a high risk OB when she does not have a high risk pregnancy is unnecessary and costly.

Family Support

A common theme that emerged both from clients who contacted TLG and from interviewing women for *The Disabled Woman's Guide to Pregnancy and Birth* was the lack of family support. Many family members were unable to be positive about their family member's pregnancy. There were two general reasons for this lack of enthusiasm: 1) They (the family members) worried about how the pregnancy would affect the woman's well being, and 2) They worried that they would have to care for the child/ren.

Pregnancy

Pregnancy can vary not only from woman to woman, but also from pregnancy to pregnancy. Many factors can cause these differences such as varying hormone levels and where the fetus is implanted in the uterus. From the 90 women interviewed for *The Disabled Woman's Guide to Pregnancy and Birth* (Rogers 2005), there seems to be a tendency that if a disability symptom is the same as a pregnancy discomfort, then the symptom could be exacerbated by pregnancy.

Pregnancy Discomforts

Fatigue

Fatigue is a common discomfort that happens most often in the first trimester. Fatigue may have more of an impact on someone with a mobility disability. If the pregnant woman is disabled, fatigue could present its own unique challenges such as transfers. If the woman needs assistance to transfer, she would need to schedule more attendant time in order to take a nap.

Some women may need to figure out if the fatigue is a normal pregnancy side effect or something else. The doctor needs to consider medications taken, possible anemia, or another common issue like thyroid problems, as well as a disability exacerbation.

Anemia is common in pregnancy and is caused by the increase in blood volume. In addition to fatigue, anemia can cause weakness, headaches, and dizziness. Mild cases of anemia in pregnancy should not cause harm to the fetus.

Thyroid problems can also cause fatigue. Low thyroid functioning may run in families. There are many symptoms that can be manifested when the thyroid is low besides having low energy such as anger, depression, agitation, migraines, and other headaches. A New England Journal of Medicine article (Haddow et al. 1999) concluded “undiagnosed hypothyroidism in pregnant women may adversely affect their fetuses; therefore, screening for thyroid deficiency during pregnancy may be warranted.”

Women with MS may need to consider that fatigue is a symptom of an exacerbation because it is one of the most commonly experienced symptoms. “Women must be very careful to get adequate rest, and to report their symptoms to their doctors in case they need medication adjustment or other treatment. Occasionally a corticosteroid may be given if the woman has an exacerbation” (Damek and Shuster 1997).

Urinary Tract Infection (UTI)

UTI is a common pregnancy discomfort for many women whether disabled or not. Women who are susceptible to UTIs because of their disability are more likely to experience them during pregnancy. It is common for women with spinal cord injuries (SCI) to get UTIs. Jackson’s study (1996) showed those women who have SCI had increased UTIs during pregnancy post injury (45.5%) compared to these same women pre-injury (8%). In addition, women with SCI also had leakage around their indwelling catheters and more frequent bladder spasms that expelled the catheter. Those who did intermittent catheterization had difficulty with catheterizing. Some had problems because the protruding abdomen occluded their vision. The majority of the women with spinal cord dysfunction (spinal cord tumors, injuries and spina bifida) who were interviewed for *The Disabled Woman’s Guide to Pregnancy and Birth* (Rogers 2005) had problems with UTIs. The results were 36% of women with spinal dysfunction experienced urinary problems compared to 17% of all women who were interviewed.

Autonomic Dysreflexia

Autonomic dysreflexia also known as autonomic hyperreflexia (ADR or AHR) is unique to spinal cord injury. The dysreflexia occurs when the injury is T (thoracic) 6 and above, because of problems in the sympathetic nervous system in response to irritating stimuli. Symptoms of dysreflexia are nausea, headache, sweating, and goose bumps below the injury.

During pregnancy some women may have more episodes of dysreflexia than when not pregnant. This may be due to many of the irritating stimuli that are associated with pregnancy. It is important for a woman to recognize what signs or symptoms usually accompany dysreflexia, so she can find the cause of the problem and be treated. “Autonomic dysreflexia is the most serious complication impacting obstetric management. Differentiating ADR from preeclampsia and understanding how to prevent and treat ADR is necessary to optimize clinical care.” (Pereira 2003)

Edema

Some swelling can occur as early as the second trimester. It generally results from the normal increase in blood volume caused by the pregnancy. Even when you are not pregnant, some fluid escapes into the spaces between cells (interstitial space). When the amount of blood increases during pregnancy, even more fluid may enter the interstitial space. Women who have limited movement generally have limited circulation which can affect the swelling. “Bilateral deep vein thrombosis can cause bilateral lower extremity edema and may be difficult to differentiate from pregnancy-associated edema.” (Burns and Jackson 2001) Therefore, precautions should be taken. If the woman is at risk, encouraging her to wear elastic stockings may be the most advantageous way to prevent deep vein thrombosis in the legs (Amaragiri and Lees 2000).

Back Pain

Back pain is common both for women with and without disabilities during pregnancy due to the following reasons: (1) During pregnancy hormones cause ligaments to relax, and pelvic joints to become less stable (this is an advantage during childbirth); (2) The abdominal muscles are stretched and weakened as the uterus grows, which causes the back muscles to work harder; and (3) The weight of the uterus puts additional strain on the lower back muscles.

Women who are disabled are often more vulnerable to back pain. Therefore, they may experience it earlier in pregnancy, while women without a disability usually have no problems until the third trimester. There are several treatment options: Having the wheelchair seating modified for pregnancy may bring about relief; Using a pregnancy support belt seems to provide extra support for the abdominal muscles and thereby support the back muscles; and Using heat and/or ice as well as a transcutaneous electrical stimulation (TNS) unit may minimize discomfort. A physical therapist can recommend exercises to strengthen the abdominal muscles.

Mobility

Pregnancy affects most women's mobility, and this is particularly true for women who have a mobility disability. Pregnancy can cause a change to the center of gravity, which can then impact transfers and walking usually by the end of the second trimester. The inability to transfer can affect many activities from toileting to bedtime. Some women who walk prior to pregnancy find that they are more comfortable using a wheelchair. However, after using the chair full time they find that they are unable to walk. To avoid permanent loss of functioning, a referral to a physical therapist can help a woman maintain her ability to walk. In addition, many women find that their ability to transfer is compromised by the second trimester of pregnancy. Having a referral to a rehabilitation team (occupational and physical therapist) can help with teaching new transfer techniques and/or maintaining the current level of functioning.

Birthing

Hospital Accessibility

The labor and delivery wards are generally not set up for someone using a wheelchair. Some hospitals have rooms with an accessible shower, but sometimes a woman may need to arrange other adaptations such as a shower seat, and/or raised toilet seat, and/or a Hoyer lift. It is

important to know that Title II and Title III of the Americans with Disabilities Act (ADA) (1990) cover this area.

Vaginal Birth

Many OBs believe that a woman will have to push the infant out using her abdominal muscles. Some physicians do not realize that the uterus is innervated by the autonomic nervous system and the uterus will do the necessary work. The 21st edition of Williams Obstetrics (Cunningham 2001) states that vaginal delivery is preferable. The text cited a study showing unnecessary C-sections, “Westgren and colleagues (1993) cited Cesarean rate of 63% but concluded that this was because of inexperience of the health care providers.” Twenty women with spinal cord dysfunction (injury or tumors or spina bifida) were interviewed for *The Disabled Woman's Guide to Pregnancy and Birth* (Rogers 2005). Twelve women delivered vaginally, seven women had a C-section. One interviewee Noelle (a pseudonym) who had Friedreich's Ataxia expressed disappointment that her first child was delivered by Cesarean section. She believed that her doctor overreacted to her disability. With her second delivery, she delayed going to the hospital causing the physician to allow a vaginal birth.

C-Section

Women with a variety of disabilities (e.g., Friedreich's Ataxia, cerebral palsy, post polio) have reported that they were told that they needed a Cesarean section. This seems to be a general trend across the country regardless of whether a woman is disabled or not. A December 2007 monthly statistical e-letter from the Center for Disease Control and Prevention states, “The Cesarean delivery rate in the U.S. increased in 2006 to over 31%, a new record high and further evidence pointing towards a nationwide change in obstetric practices.” This statistic has far reaching implications for women's health. As reported by WHO, UNICEF, UNFPA, and the World Bank (as cited in Amnesty International 2010), “the likelihood of a woman dying in childbirth in the USA is five times greater than in Greece, four times greater than in Germany, and three times greater than in Spain.” Therefore, the requirement of having a Cesarean section should not be made on disability alone.

One disability group that still may need to consider Cesarean section is women who have osteogenesis imperfecta. “If a severe but nonlethal form of osteogenesis imperfecta is suspected, delivery in a tertiary center is recommended. Method of delivery should be based on obstetric considerations and risks for the fetus and mother. If vaginal delivery is chosen, instrumentation probably should be minimized with the most severely affected fetuses to avoid intracranial trauma” (Cubert 2001).

Anesthesia

An anesthesiologist is a specialist some women with disabilities should interview before delivery because of the possible issues that women have (e.g., scoliosis and allergy to anesthesia). Also, it may also be important for women with certain disabilities to get an imaging of the spine to provide to an anesthesiologist. For example, if a woman needs general anesthesia and has juvenile arthritis “she may be at risk for subluxation of the neck, because the ligaments get eroded at C-1 and C-2 vertebrae, and her neck may become unstable. If the woman hyperextends her neck, there is a possibility that her head could cause her second vertebrae to press into the spinal cord causing quadriplegia” (Dhar July, 1997 personal communication). Also an

early consultation with the anesthesiologist gives the anesthesiologist a chance to do research. An article written by two anesthesiologists (Yeo and French 1999) discussed an alternative to using the touch method for locating a landmark in order to administer a regional anesthesia. The article stated, “administering regional anesthesia can be difficult if a person has anything unusual in her spinal area, because the anesthesiologist uses touch to find the correct point of entry. Obesity can be an issue. Scoliosis is an issue, and is not common to an OB anesthesiologist.” This article also discussed the positive aspects of using ultrasound for guiding the insertion of the catheter when the woman has spinal rods.

It is common for women with disabilities to have spinal rods; therefore, it would be beneficial to consult with an anesthesiologist before delivery. Women with spinal cord injuries T6 and above need a spinal anesthesia to control the dysreflexia during labor. “Labor analgesia should be administered early in this population of patients as it is known to prevent (or ameliorate) peripartum complications (including AHR) in laboring parturients with SCI” (Kuczkowski 2006).

While providing consultation to women, this author acquired information that seems not to be documented elsewhere. Several women with diplegic cerebral palsy (legs are affected) called TLG inquiring about effects of regional anesthesia on their disability. After having regional anesthesia, these women had difficulty walking that lasted for a period of time (weeks to months). It is unknown why this phenomenon occurred. One conclusion that may be drawn is that using touch, the anesthesiologist cannot see if s/he is too close to a nerve bundle. If the anesthesiologist uses ultrasound it may help to better guide the catheter and avoid structures. If the education or training sessions for medical personnel included disabilities, then physicians would become more familiar with disability issues, more useful questions could be asked, and alternative methods could be used to guide practice.

Case Study

Christina (a pseudonym), a TLG client, who has quadriplegic cerebral palsy was in labor for 12 hours. After 12 hours of labor, Christina wanted an epidural to relieve her labor pains. Several obstacles made this procedure difficult. The on-call anesthesiologist preferred to administer the epidural with the woman sitting. However, Christina is unable to sit independently and is obese. Since anesthesiologists learn to administer regional anesthesia by touch, the anesthesiologist was worried about his ability to insert the catheter for the regional anesthesia. He did successfully insert the catheter. He asked Christina a few questions to determine if the regional anesthesia was working and the procedure was successful. He kept asking a question he thought would determine if the catheter was both inserted correctly and working. He asked if Christina’s legs were getting numb. Because her normal muscle tone is tight due to hypertonicity (tight muscles), she did not respond, but when her doula posed the question “Do your legs feel relaxed?” Christina was able to respond.

After the Birth

Breastfeeding

When breast-feeding, the size of the breast is not related to the amount of milk produced. It does seem that women who have small breasts find nursing easier because the baby is able to latch

on easier and it requires less function in one's hands. Some women may prefer to nurse when the bra cup is cut so the areola is exposed but the rest of the breast is held away from the baby's face.

There are three groups of disabled women who have special concerns related to nursing, those who have: 1) spinal cord injuries (T-6 and above); 2) multiple sclerosis; and 3) arthritis.

As stated before, dysreflexia impacts people who have a spinal cord injury at T6 and above. Since dysreflexia can be triggered by any physical discomfort, women with spinal cord injuries are vulnerable when breast-feeding because of engorgement, infection, and the let down reflex that occurs with breast-feeding. Despite this discomfort, some women with high spinal cord injury have a strong motivation to breast-feed. One interviewee from *The Disabled Woman's Guide to Pregnancy and Birth* (Rogers 2005) states, "This was the only way I could bond with my baby--- was to breast-feed." Producing enough breast milk is another area of concern for women with spinal cord injury T-4 and above. Another interviewee who has a T4/5 spinal cord injury has sensation above the right nipple and below her left nipple. She was able to nurse from only her left breast. She said, "My milk dried up in my right breast."

Many medical professionals believe that breast-feeding can cause an exacerbation in women who have MS, however, this belief seems to be unfounded. In a study looking at MS and breast-feeding (Gulick and Halper 2002), 175 women were enrolled in the study and 140 (80%) breast-fed their infants for part or all of the 12 month period and 35 (20%) did not breast-feed. The results revealed that "of 140 mothers who breast-fed their babies 35 (25%) experienced at least one neurologist-confirmed MS relapse during the first six months and 47 (33.6%) during the 12-month period; for non breast-feeding mothers 18 (51.4%) experienced relapse by six months and 22 (61.1%) by 12 months"

On the other hand, research has shown that women with rheumatoid arthritis who breast-feed seem to be at higher risk for an exacerbation. A study from the University of Manchester, England (Barrett et al. 2000) found that women with rheumatoid arthritis may have postpartum flare ups. The flare up is probably due to the increase of the hormone prolactin. The researchers believe that "exposure to high levels of prolactin unaccompanied by correspondingly high levels of anti-inflammatory steroids could stimulate the development of RA in women."

Other issues that face women who are disabled are finding a good holding position. It can be hard to find an appropriate nursing pillow that will put both baby and mom into a secure, comfortable and ergonomic position. Lying down and breast-feeding can be either hard or painful for certain women. Therefore, it's helpful to have the woman try several positions, as well as try different types of chairs and pillows.

Postpartum Depression

"Baby blues" is common in women who have just given birth. Women who have experienced depression in the past are at risk for a severe postpartum depression. It is vital to get treatment for depression. Some disabilities such as lupus (Newell and Coeshott 1998) and MS (Foley 1998) have increased prevalence of depression associated with them. Therefore, women with these disabilities may be particularly vulnerable to postpartum depression. Medication may need to be prescribed. It is important to check which anti-depressants are safe for breastfeeding.

Build a Support Team

All new mothers need support, regardless if disabled or not. Some women with disabilities will need more support than others. Some may be at risk for an exacerbation. For example, MS exacerbation during pregnancy is estimated at only about 10 percent, but the odds rise to 20 to 40 percent after delivery. Relapses are most common six to eight weeks after the baby is born. Even with a relapse, it is important to make sure that family members and assistants have the mom feed, soothe, and play with the baby so a strong relationship can be built.

A support team can help with informational, emotional, and physical support. These forms of assistance can be particularly helpful for women with disabilities because they may face negative attitudes and discrimination from hospital staff, who may react negatively to their having a child. A strong support team provides a positive, “can do” attitude that also encourages the mother to ask questions and ask for needed help.

Conclusion

As the disability movement matures, more research and resources are becoming available for women who have a disability and who want information on reproduction. Hopefully, in the future, knowledge about the needs of women with disabilities will be included as a routine part of medical education so that health-care providers will be better prepared to offer all women the appropriate treatment and guidance they require.

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