



Original article

Health and Well-Being among Women with Physical Disabilities After Childbirth: An Exploratory Study

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A B S T R A C T

Purpose: Although research about pregnancy for women with disabilities has increased, their postpartum experience has received little attention. Studies generally focus on parenting, not on the health of the mothers themselves, despite recent studies underscoring the health risks they may face. Thus, our purpose was to examine postpartum health among women with physical disabilities, including how they maintain or improve their health.

Methods: Semistructured interviews were conducted with eleven new mothers with physically disabling conditions. A qualitative descriptive approach was used to analyze the transcribed interviews and identify themes.

Results: Nine women had delivered via cesarean section, and most had mobility impairments. Their average age was 35 years; 91% were college educated and 82% had a partner. Six overarching themes were identified: paying a price to have the baby, focus on the baby, supports—or a lack thereof, feelings of isolation, getting challenges under control/overcoming barriers, and not quite there yet/getting back to health promotion.

Conclusions: Despite their resilience in dealing with the challenges of caring for their babies within the context of their disabling conditions (including recovery from complications from the birth experience), these women clearly identified the need for additional resources and supports. They also recognized limitations to their own health that came along with their parenting responsibilities. Health care providers should be more attuned to the postpartum needs of women with physical disabilities, and policies should provide additional supports such as insurance coverage for home visits to help maximize women's health and well-being during this important life transition.

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The first weeks and months after the birth of a child present a challenging transition in women's lives (Darvill, Skirton, & Farrand, 2010; Nyström & Öhring, 2004; Walker, Xie, Hendrickson, & Sterling, 2016). These early months are marked by sleep disruptions, leading to fatigue (Badr & Zauszniewski, 2017). Some women may also experience stress, mood changes, and physical symptoms, such as pain and problems with breastfeeding (Declercq, Sakala, Corry, Applebaum, & Herrlich, 2014; Liu, Phan, Yasui, & Doan, 2018; Schytt, Lindmark, & Waldenström, 2005). Social support from family

and other mothers is especially important during this time; without it, women can become isolated (Darvill et al., 2010; Razurel, Kaiser, Sellenet, & Epiney, 2013). For mothers with physical disabilities, all these challenges can occur along with added complexities, given the context of disability.

Approximately 9% of women who give birth have a chronic disabling condition such as a musculoskeletal condition, asthma, or a mental health diagnosis (Sumilo, Kurinczuk, Redshaw, & Gray, 2012). An estimated 6.9% of pregnant women in the United States have a physical disability, such as a mobility limitation (Iezzoni, Yu, Wint, Smeltzer, & Ecker, 2013). Nevertheless, the prevailing paradigm for the transition into motherhood is situated within the context of nondisabled women, thereby failing to recognize the experiences of women with disabilities (Lawler, Begley, & Lalor, 2015). For these women, the transition to

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motherhood can bring challenges to health beyond those experienced by nondisabled mothers, thus highlighting the intersectionality of postpartum and disability status. Yet research on the health of mothers with disabilities has concentrated mainly on pregnancy experiences and birth outcomes (Mitra, Clements, Zhang, Long-Belil, & Mitra, 2015a; Morton, Shahbandar, Hammond, Murphy, & Kirschner, 2013), not on women's health during the postpartum period. Equal attention to mothers' postpartum health is warranted.

Research on the postpartum period for women with physical disabilities has focused primarily on the added challenges of motherhood (Andrews & Ayers, 2016; Smeltzer, 2007). For those whose mobility or upper body strength is limited, for example, the care of an infant can be particularly difficult, especially for bathing and transferring the baby to and from a crib (Andrews & Ayers, 2016). Additional barriers include limited accessible or reliable options to transport young children. During the postpartum period, women with disabilities are also at higher risk for depression (Mitra, Iezzoni, et al., 2015b), social isolation (Walsh-Gallagher, Sinclair, & McConkey, 2012), and tobacco use (Mitra, Lu, & Diop, 2012) than are women without disabilities. They may also be wary of going for visits to health care providers because of previous negative experiences within the medical system (Mitra, Clements, et al., 2015a; Walsh-Gallagher et al., 2012).

Mitra, Long-Bellil, Smeltzer, and Iezzoni (2015c) have proposed a comprehensive "perinatal framework for women with physical disabilities" (p. 499). This framework integrates social, psychological, behavioral, environmental, and biological factors that influence perinatal health. In this model, access to information and resources, health care-related factors, psychosocial factors, and social support mediate the relationship between individual factors (e.g., demographics, health, body structure and function, impairments) and maternal and infant outcomes. The environment (e.g., accessibility, community attitudes, policies) is proposed to impact all of these factors. For example, the authors state that laws and policies such as the Americans with Disabilities Act and the Affordable Care Act impact access to affordable, appropriate, and available health care services. The existence of good quality transportation can also affect women's ability to access these services (Bezyak et al., 2019). Good access to health care can in turn positively influence health outcomes for mothers and their babies. Yet even this innovative perinatal health framework does not address factors that contribute to maternal health after pregnancy.

Thus, although researchers have begun to study how women with physical disabilities experience pregnancy, these women's postpartum experiences outside of parenting challenges have received little attention. Research has addressed parenting adaptations, barriers encountered, and resources needed by new mothers with physical disabilities (Jacob, Kirschbaum, & Preston, 2017; Wint, Smith, & Iezzoni, 2016), but research has not focused on the women's own health. However, a recent study has documented higher rates of emergency room visits and hospitalizations postpartum among women with intellectual and developmental disabilities, compared with those without these disabilities, thereby highlighting the need to research maternal health after childbirth (Mitra, Parish, Akobirshoev, Rosenthal, & Moore Simas, 2018). Maximizing postpartum maternal health may aid in reducing the longer term risk of mortality faced by women with disabilities, especially from heart disease and stroke. It is also important for women's health in any future pregnancies (DeCesare, Jackson, & Phillips, 2015; Forman-

Hoffman et al., 2015). Thus, in this exploratory research, we focus on maternal postpartum health broadly defined to include physical and emotional health status, self-perceived health, and activities undertaken to maintain or improve health. Understanding the broader context of postpartum barriers and facilitators related to what women with disabilities do to promote their health can help providers help them to maximize their health and well-being during this important life transition.

Methods

Given limited prior research, in this study we decided to take a qualitative descriptive approach to explore the perceptions of postpartum women with physical disabilities. This methodology enabled us to use low-inference interpretation to understand these mothers' health, including what they were doing to maintain or improve their health postpartum (Sandelowski, 2000).

To be included, women had to be between 18 and 44 years old, have given birth to a child within the last 3 years, be able to read and converse in English, be able to engage in video conferences, and have a self-identified physical disability or impairment. The latter was confirmed by responses to five questions about functional ability used in national surveys such as the *Behavioral Risk Factor Surveillance System Questionnaire* (2013). Items covered use of special equipment, such as a cane, walker, or wheelchair; difficulty dressing or bathing; difficulty walking or climbing stairs; difficulty using fingers to hold or handle; and other functional limitations.

After approval from the Institutional Review Board at the University of Texas at Austin, notices were posted on the National Research Center for Parents with Disabilities website and listservs for people with disabilities. A total of 19 mothers contacted the research team about the study. Three were ineligible and five were eligible but did not schedule an interview, so a total of 11 women participated in the interviews.

The Interview Process

A PhD-prepared nurse researcher with extensive adult health clinical experience (C.S.P.) conducted all interviews. Trained in qualitative research methods, the interviewer had conducted interviews in multiple studies with women who have chronic disabling health conditions. She initially contacted each of the 19 women who had expressed interest, to describe the study and determine eligibility. She then sent the eligible women a packet of study materials (including a short background information survey) and a consent form to sign. When the materials were returned, the interviewer scheduled the interview at a time that was convenient for the woman. All interviews were conducted using the video-conferencing platform Zoom, which enabled the interviewer and the mother to view each other face to face. The mothers received a \$25 gift card as appreciation for their time.

An interview guide was used, informed by both existing postpartum literature (Walker, Sterling, Becker, Hendrickson, & Xie, 2018) and the authors' previous experience in conducting research with new mothers and women with physical disabilities. The guide contained questions about the mothers' current health, postpartum health care, and what they were doing to maintain or improve their health (Table 1).

When the interviewer began the interviews, she told the women that their interview would focus on "YOUR physical health and emotional well-being."

Table 1
Interview Questions for Mothers with Disabilities

1. <i>Opening Question</i> : How would you describe your health since you had your baby?
2. Women's emotions can be on a roller coaster after delivering a baby. Compared to how you felt before you had the baby, have you felt more overwhelmed, more emotional, more anxious, or more depressed?
3. Women can have a number of concerns about their health after having a baby. For example, how do you feel about how your body changed after pregnancy?
4. After you had your baby, did you have a 6-week follow-up visit with your doctor, midwife, or nurse practitioner? What was discussed?
5. What are you doing to take care of your health now?
6. Is there anything else I haven't asked about your health after having the baby that you would like to discuss?

After the interviews, the interviewer debriefed with the first and third authors and discussed broad themes that she observed. During the debriefing, she indicated that she felt she had reached saturation with the 11 interviews because new issues were not emerging, which is similar to the experience reported by [Guest, Bunce, and Johnson \(2006\)](#).

Analysis

The audio-recorded interviews were transcribed by a professional transcription service. An author (L.W.) checked the transcripts for accuracy against the recordings. Informed by the analytic approach proposed by [Miles and Huberman \(1994\)](#); an author (H.B.) next independently developed categorical codes based on the interview questions, a review of the transcripts' content, and the debriefing comments from the interviewer (C.S.P.). An author (E.W.) also reviewed the interviews and coded them independently. Both authors considered patterns in the data as they developed their codes. Methods to ensure trustworthiness included transcription rigor, peer review/debriefing, group reflexivity, investigator triangulation, and searching for disconfirming evidence. To promote the trustworthiness of the findings, for example, the two authors (H.B., E.A.) debriefed with a third author (L.W.) to compare codes and identify emerging themes that depicted the phenomena of health in the postpartum period. Acknowledging their different frames of reference, this meeting also promoted reflexive thinking about the meaning of the findings.

Results

Sample Description

The women were 35 years old on average (range, 29–43 years); most were college educated; 82% lived with a husband or partner. They had given birth to their youngest child approximately 2 years previously ([Table 2](#)). Nine of the 11 women had delivered via cesarean birth, and all but two of them had breast fed their infants for at least 2 weeks. The women had various diagnoses (most resulting in mobility impairments, such as spinal cord injury); many had multiple health problems.

Themes

In our analysis, we identified six overarching themes: paying a price to have the baby, focus on the baby, supports—or lack thereof, feelings of isolation, getting challenges under

Table 2
Participant Characteristics

	No.	%
Education		
High school graduate/GED	1	9
College graduate	4	36
Graduate degree	6	55
Race/ethnicity		
Non-Hispanic White	7	64
Hispanic	1	9
Other/multiracial	3	27
Total household income		
≤\$15,000	2	18
\$20,000–\$60,000	2	18
>\$60,000	7	64
Relationship status		
Living with a partner	9	82
Living alone	2	18
Employment		
Employed	4	36
Not unemployed	7	64
Delivery		
Cesarean	9	82
Vaginal	2	18
Infant feeding		
Breastfeeding	6	55
Formula or combination	5	46
Health status		
Good/very good	9	82
Fair/poor	2	18
Average age of mother, years	35	
Average age of youngest child, months	24	
Average number of children at home	1.4	

control—overcoming barriers, and “not quite there yet”—getting back to taking care of my health. Some of themes encompassed subthemes. For example, paying a price to have the baby included subthemes such as the perception by some women that their health status had been weakened by childbirth and its aftermath; some themes overlapped with others.

Paying a Price to Have the Baby

When asked to describe their health since their baby's birth, three women stated their health was worse and a fourth discussed her difficult recovery from childbirth. Three women defined their health as fair or “up and down.” Yet another described her health as “a bit of a challenge.” However, one woman with cerebral palsy whose hips and back “got out of alignment” during pregnancy stated that her postpartum health was better than she and her provider team had expected. Only one woman described her health as good and another indicated there had been no change.

This overarching theme encompasses subthemes, such as difficult deliveries leaving women with ongoing health problems. One woman stated, “when I first had her it was one of the first times that I felt disabled in a long time.” She had a uterine abnormality, perhaps because of multiple previous surgeries, and that made her cesarean delivery particularly difficult. For the first time, she developed a pressure sore, which she attributed to her maternity care in the hospital:

When they got me out of my bed, you know, they were sliding me across the bed. You know, I, I couldn't do it myself. I normally transferred myself, no problem at all, but I needed help. In the hospital, we had problems with like my catheter clogging. They didn't know how to handle that.

She said that, after her emergency cesarean, “it took a while for me to get my body back and start feeling like I’m back to normal.” In contrast with this negative experience, another woman described her provider in positive terms: “she went beyond doing her work ... doing a lot of research, so she could better understand my situation.”

Another subtheme consisted of negative impacts of pregnancy or childbirth on functioning and symptoms. Two women described functioning becoming more difficult while they gained weight during pregnancy, requiring the use of a different wheelchair or help with bathing. Others spoke of pain. One discussed needing intermittent catheterization owing to a group B streptococcus infection that occurred during pregnancy and had not resolved. Some of the problems that the mothers experienced affected their core musculature, resulting in diminished strength. This in turn affected their ability to care for their child. As one stated, “Doing the (physical) work of caring for a baby ... set me back a lot.”

Another subtheme was psychological distress. When asked about emotional changes, a number of the mothers spoke of depression and anxiety before and/or after their child’s birth. One woman described her concerns as follows:

I had a lot of anxiety throughout the entire pregnancy, just being concerned about a loss, or some issue that could happen. And that ... progressed into postpartum feelings where I was just always concerned, like I was afraid to—I didn’t even want to be alone with him. I was scared. I didn’t want to be in a position where I couldn’t help him if I was alone. Um, it did affect my mental state pretty deeply.

For her, occupational and physical therapists who came to her house were especially valuable, because they showed her how she could safely lift and carry her baby.

Access to services, particularly mental health services, could be difficult for these women. This was a key subtheme. One woman related that after scoring “high” on a mental health screening in the hospital, the staff offered to send a social worker to her home but could not schedule anyone for at least 2 months. This mother, who experienced panic attacks shortly thereafter, said that she needed help sooner: “if you’re not going to send somebody for 2 months anyway then you must not be really all that worried about me.” She then made the following comment:

It got to a point where, I was having panic attacks and things like that, and needed to go see—to get professional help and I wonder sometimes if somebody had come in earlier if I could have avoided that.

Others said that they had to decrease their psychotropic medications during pregnancy or while breastfeeding, which they believed to have worsened their mental health problems. One of the women said that there should be a way for mothers to report postpartum symptoms to their providers without fearing that child welfare would take their children away—a particular concern for mothers with disabilities.

Focus on the Baby

All of the women focused strongly on how to care for their children postpartum. As their infants grew, some women found them easier to care for, although others said that keeping up with an active toddler was difficult because of their own physical limitations. Bathing the child or taking the child to the grocery store could be challenging, especially for wheelchair users. Assistance from family members was especially important. Some

women stopped eating well or regularly because they focused exclusively on their child’s need to be fed. As one mother stated, “I definitely have not had as much energy to do my physical therapy because I’m prioritizing putting my energy into what my baby needs. So I have definitely become a lot weaker.” Her comment illustrates the overlap between the themes of focus on the baby and paying a price to have the baby.

Many of the women had breastfed their child, and for them this was an important symbol of their ability to provide something that only they as mothers could offer to their babies, fulfilling a mother’s role without disability-related limitations. One woman stated, “I was very bound and determined to be breastfeeding 100%. And that also, I think, contributed to my anxiety about not being fulfilling as a mother.” She then related that her provider put her in touch with a lactation consultant, who was very helpful. However, another woman reported that her breastfeeding was contributing to lower bone density, and her provider encouraged her to discontinue the feedings.

Supports—or Lack Thereof

Virtually all of the women received family support, especially from partners. However, some also mentioned assistance from health care professionals. One woman mentioned a nurse’s home health visit, which she termed “invaluable.” Another mentioned accessible transit to an on-site parenting class. Yet another reported having a postpartum doula to help with activities of daily living. Some of the women commended their health care team, as the following comment illustrates: “I think I’ve gotten lucky that I have a, a team [of providers] that really does a lot making sure I kind of stay on top of things.” Others stated that they would have liked to have more professional help, but that such help was not covered by their insurance. This comment reflects another dimension of the problem with accessibility that some women experienced. With respect to physical accommodations, the women discovered that cribs and car seats were often inaccessible or difficult for mothers with physical disabilities to use. Yet another woman described living an hour away from all her doctors, causing her sometimes to put off needed care.

Feelings of Isolation

Although the women generally had family support, many still felt isolated. For example, either those whom they knew in the disability community were not mothers, or other mothers whom they knew did not have disabilities. Consequently, it was difficult for them to find peers who shared their experiences and could provide guidance. A woman with spinal cord injury stated:

Maybe I can find someone who can, you know, just guide me. But there wasn’t. I wish I could have someone, you know, that can tell me “Yeah, you’re going to be fine” or “You can just do this so it will be easier for you.” But there was no resources for me.

For some mothers, health problems after delivery also contributed to isolation, because they were less mobile than before. However, one woman stated that having friends with disabilities or friends with chronic pain provided helpful social support: “We also kind of like trade ideas and things like that.”

Getting Challenges under Control—Overcoming Barriers

The women demonstrated their resilience through examples of creative problem-solving that they provided, particularly with

respect to the physical challenges of parenting. As one stated, "I'm a problem solver. I figured out how to do stuff." Despite limited resources for adaptive parenting equipment, many of the women and their families came up with creative solutions, such as modifying a crib so that it could be attached to the mother's bed to make reaching the baby easier. Others experimented with repositioning nursing pillows to accommodate their wheelchair use. Another woman described signing up for various services, such as Head Start, which provides additional referrals to community resources. Positive attitudes about motherhood were illustrated by the following comment:

It's an amazing experience, especially when you have been living with the mentality that you are not going to be a mom. And then suddenly, it's like, okay. Well, I guess I'm going to be a mom, then ... So, I'm embracing every moment.

"Not Quite There Yet"—Getting Back to Taking Care of my Health

All of the women reported that they did see their maternal health providers postpartum, but most of these visits were focused on recovery from cesareans. A few women did recall that they were screened for depression, but only one remembered her provider asking her what she was doing to take care of her health (i.e., eating healthy).

When asked about health activities that they engaged in, the women listed a number of behaviors. These included healthy eating, trying to get good sleep, and exercising (which was often particularly challenging). Two mothers mentioned that chasing after a toddler could contribute positively to their levels of physical activity. Another woman began a swim class with her baby. She described it as "very exhausting," but stated, "I see that as for me, doing something proactive for my health as well."

A key subtheme of getting back to taking care of health was self-management of chronic conditions, such as through physical therapy or managing pain and medications. For example, one woman described beginning a new respiratory hygiene program. For a number of mothers, weight gain was particularly concerning. Their concern was not necessarily because of their appearance, but because increased weight interfered with their ability to transfer or care for the baby.

A few women talked of efforts to improve their psychological health. One described having been anxious throughout her pregnancy, and this continued into the postpartum period. She did get help when her son was 8 months old, and she is now using anxiety medication. Another said she that had always struggled with anxiety and depression, which she "put on the back burner." However, she reflected that she decided to begin counseling because there was now a child involved.

The women generally indicated they were trying to "get back" to health-promoting behaviors that they had performed prior to the birth of their child. One stated that she had to put her own health first so that she could care for her child. However, a lack of time and energy created barriers to self-care. Some of the women discussed carefully planning their activities to avoid becoming too fatigued. Another pointed out that a mother with disabilities has to be aware of taking care of her health more than do women without disabilities, who can "push it off for a longer period of time." For a woman with a disability, "you just don't have that margin of error."

Discussion

To our knowledge, this is the first study to explore the perceptions of new mothers with physical disabilities regarding

their own health as opposed to their babies' health. Previous studies have documented the challenges that women with disabilities face during the prenatal and perinatal period (Mitra, Clements, et al., 2015a; Morton et al., 2013), but what happens to women after childbirth is less well-understood.

The women in this study were resilient in managing the challenges that they faced in delivering their babies and in coping with the demands of childcare. This finding is consistent with Gill's (1995) discussion of problem solving and adaptability as core values of the disability culture. Despite their challenges, not one of the women expressed any doubts about having a child.

Nine of the 11 women had cesarean births, and many experienced difficult recoveries from that surgery. Women with physical disabilities have twice the odds of having cesarean births than do women without disabilities (Darney, Biel, Quigley, Caughey, & Horner-Johnson, 2017). The National Institute of Child Health and Human Development (2017) has identified the following factors as indicative of high-risk pregnancy, and these factors may make cesarean births more likely: a) existing health conditions, b) overweight and obesity, c) multiple births, and d) young or old maternal age. We did not have access to medical records, so we were unable to determine the reason for the high number of cesarean births in this sample, but the high number of cesareans in women with physical disabilities merits further investigation.

Among nondisabled pregnant women, common concerns include increases in body weight, changes in shape (e.g., increase in waist size), changes in muscle tone, and stretch marks (Walker, Timmerman, Kim, & Sterling, 2002; Watson, Fuller-Tyszkiewicz, Broadbent, & Skouteris, 2015). In contrast, the women in this study tended to discuss functional loss or damage from surgery that was sometimes reflected in changes in appearance. For example, one woman who lost the ability to transfer independently during pregnancy stated that her body was now back to normal. Her ability to transfer again meant to her that she "had made it," thus reflecting a focus on regaining function more than on appearance. Although many new mothers have body image concerns, disabled women may have greater acceptance of their body image because physical bodies of disabled women already tend to violate traditional gender norms in aesthetics and shape (Taub, Fanflik, & McLorg, 2003). Nondisabled people likely take bodily function and independence for granted, but these aspects of body image are most salient for disabled women (Bailey, Gammage, van Ingen, & Ditor, 2015).

A number of the women did acknowledge feelings of anxiety or depression. Because some women had experienced anxiety and depression before the birth of their child, they did not necessarily consider this to be postpartum depression or anxiety. Both depression and anxiety are key mental health concerns during and after pregnancy (O'Hara & Wisner, 2014; van de Loo et al., 2018). Messages exhorting new mothers to be the "perfect mother" can put enormous pressure on any woman, especially mothers with disabilities who may already be struggling to balance their lives within the context of their disability. Changing expectations from the "perfect mother" to a "good mother" could help to decrease that stress.

Like many women without disabilities (Berge, Larson, Bauer, & Neumark-Sztainer, 2011), many of these mothers had subjugated their own efforts to improve or maintain their health as they dealt with the demands of childcare. At least one woman, however, recognized that she needed to put her own health first so that she could care for her child. Helping women to

understand that taking care of themselves is essential to caring for their babies might help them to focus on health-promoting behaviors that many put on hold postpartum. For some women whose health and functional abilities may have been compromised by childbirth, these activities must take into account their “new normal.”

Most of the mothers had breastfed, which many women see as enacting the mother's role (DeMaria, Ramos-Ortiz, & Basile, 2020). Breastfeeding may be an important component of health and well-being for these women. At the same time, however, some research has suggested that breastfeeding could contribute to bone loss (Dursun, Akin, Dursun, Sade, & Korkusuz, 2006). Therefore, mothers with physical disabilities who may already have a higher risk for osteoporosis in comparison with women without disabilities (Welner, Simon, & Welner, 2002) may need specific, specialized guidance in this area.

Although relationships with providers were not a major focus of the interviews in this study, some women did relay experiences that suggested limitations in providers' ability to care for them during pregnancy and delivery. Such problems have been repeatedly documented in the literature (Mitra, Clements, et al., 2015a; Sonalkar, Chavez, McClusky, Hunter, & Mollen, 2020). In contrast, other mothers in the study commented positively on their providers. Thorough, compassionate care was recognized as especially valuable. As Clements, Zhang, Long-Bellil, and Mitra (2020) have pointed out, more comprehensive family-centered care is especially important for families with mothers who have or are at risk for having disabilities, because the health of children and parents are inextricably tied together.

Many new mothers have difficulty keeping up with medical appointments when caring for a new child, and time and transportation can be particularly problematic for women with disabilities (Andrews & Ayers, 2016; Bezyak et al., 2019). Yet these mothers may be especially in need of contact with health professionals if they have more complicated physical conditions that have been compromised by their delivery. This is consistent with DeJong et al.'s (2002) conclusion that people with disabilities may require more complicated and lengthy treatment than nondisabled individuals do, as a number of the nine women in this study who had a cesarean delivery suggested. Home visits from knowledgeable health care providers may be exceptionally valuable—especially when one considers the isolation that many of these women experience. Further, providers should be aware that women with disabilities may be less likely to spontaneously disclose their struggles to health care providers. For example, one woman in this study expressed caution about bringing up mental health concerns owing to the perceived threat of child welfare involvement. Such fears are not unfounded; across the United States, women with disabilities and their children are referred into the child welfare system at a disproportionately high rate, often inappropriately (National Council on Disability, 2012). In Minnesota, for example, parents identified as having a disability were found to be three times more likely to have their parental rights terminated than those not labeled as disabled (LaLiberte, Lightfoot, Mischra, & Piescher, 2015). This potential threat underscores the importance for health care providers to develop cultural competence in working with disabled women and their families (Andrews, 2019).

This study has certain limitations. The sample was small and self-selected, recruited through website forums and social media groups for parents with disabilities. Moreover, the study was

limited to women with physical disabilities. Most women with disabilities are not as highly educated, do not have as much income and access to health care, or may not have as much spousal support as did the women in this study (see Iezzoni et al., [2013] for demographic characteristics of pregnant women with disabilities). Other mothers may struggle with resource constraints more than these women did. In addition, women who are not as connected to the disability community may feel even more isolated than these mothers, which is consistent with literature that suggests that peer support is a valuable asset to disabled parents (Andrews & Ayers, 2016). To this end, Peterson-Besse, Knoll, and Horner-Johnson (2019) have reported that postpartum women with physical impairments rated informational support from women with disabilities they met online higher than informational support from their health care providers. This finding highlights the importance that mothers with disabilities place on connections with other women with disabilities and the usefulness of peer-led parenting support communities, such as the Disabled Parenting Project. Finally, although we decided that we were reaching saturation in the themes expressed in these 11 interviews, more interviews might have revealed additional insights about the health of women postpartum, particularly if the sample had been less homogeneous.

Implications for Practice and/or Policy

Consistent with the factors identified in Mitra's model, many of the themes identified in our interviews have policy and practice implications. Public policies should be revised to improve access to assistive technology as well as access to childcare assistance, so that new mothers can maximize their health and well-being during this important time in their lives. Modifications in insurance coverage to allow for home visits to these women who may be at high risk for health complications should be a priority.

This study has clear implications for health care providers as well. All of the mothers in this study did have a follow-up visit with their provider. Although these visits seem to have focused largely on “checking the incision,” this visit includes an excellent opportunity for providers to have a broader discussion about what women can do to maintain or improve their health postpartum. Given the increased vulnerability that many women with disabilities may have to health problems because of their disabling conditions, it is particularly important for providers to encourage them not to ignore their own health at a time when their attention is so clearly focused on their babies' needs. Interestingly, one of the women interviewed actually used the phrase “thinner margin of error” when talking about how essential it was for mothers to maintain their health.

Some of the women in the study did ask their providers for practical suggestions about childcare, but the providers seemed unaware of helpful resources such as the Disabled Parenting Project (<https://disabledparenting.com>), the National Research Center for Parents with Disabilities (<https://heller.brandeis.edu/parents-with-disabilities/>), and the Looking Glass (www.lookingglass.org), all of which are national resources that provide online support to parents with disabilities. Given the isolation that these women reported (i.e., being the only disabled mother they knew), providers need to recognize their added responsibility for helping mothers with disabilities locate resources to help them care for themselves and their babies after childbirth.

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