



Postpartum 'Normalcy' Can Be Elusive

By KATHLEEN BENTON, Ph.D., and HELEN ELIZABETH MCINTOSH, MD

Although terms like “baby blues” and “postpartum depression” have made their way into the popular culture, medical literature points out that depression isn't the only challenge to a woman's sense of wellness after childbirth. In fact — though often mild — post-pregnancy medical issues are frequent. It therefore may be more difficult and take longer than she was led to expect for a new mom to return to her pre-pregnancy state of physical and emotional well-being.

She also may find that the physical changes that come with pregnancy and childbirth bring on emotional challenges complicated by such factors as socioeconomic status, presence or lack of social support systems and personal and social expectations regarding motherhood. It's easy to see how a variety of factors can negatively affect her health.

Like many health systems, St. Joseph's/Candler Heath System in Savannah, Ga., has put resources in place intended to support postpartum women and address some of their needs at the critical time when they not only are physically and psychologically vulnerable, but also have an infant depending on them for care.

Although these programs are steps in the right direction, we regard them as just a start. Now that the majority of new mothers and babies are discharged from the hospital within 24 to 72 hours after delivery, nurses and health care providers are challenged to ensure that mothers and newborns receive comprehensive and high quality post-discharge care. Granted, providers and community-based programs have increased outpatient support, but based on our experience as mothers

and, particularly, as medical professionals — an OB-GYN, a nurse practitioner who works with women during and after childbirth and a clinical ethicist — we strongly believe women need much more support in the postpartum period than most hospitals provide.

The physiological and psychological symptoms women may experience following childbirth are a poorly understood and under-discussed niche within health care. In a typical scenario, women who may have been followed medically through 40 weeks of hormonal changes during their pregnancies are scheduled for a single postnatal office visit six weeks following delivery. As new mothers typically

perceive it, the expectation is that she will feel normal and well at the time of this visit. However, as the new mother adjusts to another round of hormonal changes at the same time as she is fac-

ing new physical and emotional challenges, she may find it hard to live up to this perceived expectation.

Readmission rates can be influenced when clinical diagnostic testing and monitoring during labor and delivery do not detect all potential issues that could complicate recovery. A mother may have a very normal physical assessment during her short hospitalization. However, the physiologic changes associated with even a normal pregnancy — shifts in hormonal levels, alterations in metabolism, pain and discomfort, stresses at work or home — are just a few of the factors that may contribute to development of postpartum problems.

Given the often subtle symptoms of postpartum stress, the complexity of the hormonal changes going on in a woman's body and the widespread expectations of women that this should be a happy time, women who are feeling physically or emotionally challenged may be reluctant to admit they are having problems.

The average postpartum mother does not anticipate that she will be one of the “unlucky” ones who have to monitor their blood pressure, see a specialist, take new medications or see a doctor frequently. Mothers during this time are expecting to recover normally and are looking forward to adjusting to the joys and surprises of motherhood, and bonding and caring for their newborn. When this expected plan is altered by a complication of pregnancy or delivery that calls for unanticipated medical treatment, new mothers may grieve the loss of a normal and rapid recovery, especially since pregnancy and delivery are not viewed by society as empathetic illnesses.

Here are a just a couple of examples — true stories which, though not necessarily typical, may help to illustrate what new mothers might face:

■ A 30-year-old gave birth to her second child following an uncomplicated pregnancy. However, her desire to breast-feed as well as to mother two children with equal attention made for a challenging emotional time postpartum. Day five, post-delivery, the woman was not feeling well. She was headachy and unsure of whether to blame the sleeplessness common to mothers of newborns or something more for her general malaise. Fortunately, she did visit her doctor and was diagnosed with postpartum hypertension. The transient hypertension disappeared after she weaned her baby five months later, but the woman felt that, in addition to her short-lived medical problem, her postpartum emotional state was compromised because she was so affected by her expectations, anxieties and hormonal imbalances on any given day.

■ A 32-year-old mother of four has come to dread the postpartum period much more than pregnancy and childbirth. She was in very good

overall health but suddenly experienced chronic and debilitating symptoms following the birth of each of her first three children. Symptoms began three to four months postpartum and included chronic fatigue, lethargy, insomnia and migraines. She sought medical treatment from several specialties with no relief. The woman became withdrawn and depressed when physicians were unable to provide a diagnosis and resorted to explaining her issues as fatigue attributed to sleeplessness. Fortunately, this woman had the social support and resources to push for a resolution to her problem. After more thorough testing, she was found to have a rare anemic disorder requiring massive amounts of iron. Sadly, the specialists she had consulted were satisfied with their simple answer and didn’t look any harder or really focus on helping her. Understandably, this woman had expected more from her physicians.

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may be reluctant to admit they are having problems. Granted, most of these problems are unlikely to develop into full-blown physical abnormalities or serious clinical depression, but greater social support would let these moms know that they are not alone and that it is OK to reach out for help.

The first of two initiatives at St.

Joseph’s/Candler is called First Steps. This program for families of newborns began with a state-funded startup grant and is now sustained through hospital support. The program provides a full-time employee responsible for visiting moms prior to their discharge to assess their readiness to care for themselves and their child and to address any anxieties they might express. The employee offers a list of resources for support and provides for check-in by telephone a few weeks after discharge. (As a sign of the need for more help for new mothers, Johns Hopkins University School of Medicine, with funding from the U.S. Department of Health and Human Services, Administration of Children and Families, is evaluating Georgia’s First Steps programs to assess their levels of functionality and success and to identify components that need strengthening. St. Joseph’s/Candler was selected to participate in the study. The research will include data collection through survey distribution for a firsthand response on where the needs are and how women are served.)

St. Joseph’s/Candler offers additional resources that piggyback First Steps, including a “Mommy and Me” support group run by a lactation consultant. The hospital also, in conjunction with Mental Health America, provides the Project Health Moms Warmline, a call-in portal staffed by registered nurses, that allows new mothers to talk with both staff nurses and with new mothers who have experienced similar issues or symptoms. Mothers who are having issues of any kind with infants or other children, who are feeling depressed or simply feeling overwhelmed or having trouble with decision-making, may call in to get help or referrals to counselors or medical professionals if needed. The overall goal is for mothers to have seamless support during this time in case “unexpected” postpartum health issues crop up, in order to promote timely return to their



pre-delivery baseline health status.

Although these are good programs as far as they go, they rely on the new mother to initiate contact, which, for various reasons, she may be hesitant to do. For example, her own expectations of wellness may inhibit her from reaching out, or, because the Warmline is phone-based, she may not feel she has sufficient privacy or uninterrupted time to discuss her problems with a stranger.

St. Joseph's/Candler is pursuing additional measures to help fill the gaps for women who are unknowing, embarrassed or generally reluctant to seek help when met with unexpected physical and mental instability. Our clinical education specialist is currently pursuing a grant from the National Institutes of Health (NIH) for a program based on NIH's recognition that reducing the burden of mental distress during the perinatal period will contribute to mother and family wellness.

The goals of the NIH program are research and intervention. Through better intake mechanisms of checking up on moms after childbirth as a research component, the model will consider the possibility of postpartum issues unknown to the mom. In lieu of asking her to seek help, every new mother will be contacted in the weeks following discharge to take part in a screening to assess both her physical and psychological symptoms. The mother also will be asked at the end of the screening if she would be open to peer counseling at no cost and with complete flexibility of time, circumstance and location.

Willing participants would enter the Phase Two intervention component, a mental health peer-to-peer volunteer counseling group. In this model, volunteers are recruited, screened and provided a 12-week training program to fulfill goals of listening, help with processing and successful peer sup-

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port. This community-based approach would alleviate additional burden on the direct clinical system (which may be needed in some cases), while reinforcing camaraderie among participants and counselors. By providing a structured peer group outlet, medical professionals can monitor participant progress and develop the program further.

More broadly, though, we believe that we are far from alone in seeing a need to address the gap in support for women during the postpartum period. Through our work at St. Joseph's/Candler, we have developed these guidelines that we believe should be part of any strong program for new mothers:

- Meet women where they are. Reach out to new mothers at regular intervals during the first six months post-delivery. Most facilities have resources available but don't actively reach out.

- Expand programs (like First Steps) to initiate contact as early as possible rather than waiting for delivery, understanding that this may require some creativity and initiative. For example, timely outreach might take place in the physician's office during the final visit prior to birth. Providing support literature at this time, rather than during the whirlwind that often follows a birth, would give women more time to read it and file it away for future use.

- Develop education and outreach to clinicians that helps them understand postpartum issues so they may be

more responsive and proactive. Expand the practitioner-patient dialogue to convey to women that they may not achieve absolute wellness by the six-week postpartum visit and that they may experience issues in the interim that require additional attention.

- Provide for peer support. It is our experience that new moms want to talk with others who have survived this difficult period. Provide and facilitate a means for volunteer mothers to reach out and visit new moms.

- Encourage a woman's personal support system, especially her spouse or partner, to be engaged in taking care of both baby and mother and to be alert to her need for extra physical and emotional support.

We realize that our suggestions may appear rather daunting, but we see them as necessary steps toward changing a social mindset. Until we change how the community supports mothers, women will struggle with these complex issues.

Many Catholic hospitals are noted for their excellent childbirth facilities and carry a strong influence in the current paradigm. We should also lead the charge for change.

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