Giving New Life in More Ways Than One: Reimagining Mental Health Support for Pregnant Women

Honors Capstone Paper

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I. INTRODUCTION

For some, the arrival of a new baby is nothing short of a sublime dream. For others, the experience that is considered exclusively positive turns into a nightmare.

In 1995, Susan Smith intentionally rolled her car into nearby John D. Long lake with her two young sons Michael and Alex strapped inside. Fast forward to January 2023, and Lindsay Clancy is plagued with the conviction of murdering her three children Cora, Dawson, and 8-month-old Callan, with her attempted suicide following the fateful event. Lindsay is now beginning physical recovery as a paralytic, while her husband pleads with the public to forgive the “real Lindsay” whom he says was known as entirely loving, caring, and selfless. Two singular snapshots alone have shown that the unresolved and typically ignored misfortune of postpartum depression and psychosis has truly stretched over decades.

When the issue is truly analyzed, it reveals wide gaps in the perinatal care of expecting women. Emphasis is placed on educational sessions about timely checkups, the agenda for gaining weight, fetal nutrition, and sex instruction. Physical training sessions such as standard Lamaze classes that teach breathing exercises during labor are consistently incorporated in care as well. But I cannot help but wonder: where are the classes that prepare women for the sincerely frightening aspects of labor – the possible complications, the fears they may possess, and the mental turmoil that can ensue even with a healthy baby in tow? It is hard to believe there is still not a standard for mental health care of expecting women today in the same way there are standard physical health care classes. With postpartum depression affecting up to 15% of new mothers yearly and afflicting them 50% of the time for more than six months, I believe there is a

strong necessity for focused, newly adapted education sessions in the second trimester for pregnant women from obstetricians and midwives.

II. THE SCOPE OF THE ISSUE

Focusing on patching the aforementioned gaps first requires a deeper insight into the problem itself. Postpartum depression (PPD) is a mental disorder specific to new mothers. Its core is a persistent sadness and hopelessness spanning a few months up to a couple years after having a child, commonly but not wholly related to role changes, loss of personal identity, fear of change, and traumatic births. The star of the postpartum period tends to be the adorable new child and his or her health, but there are dire consequences of withheld attention on the recovering mom. More often than not, the unspoken expectation of others for her to be absolutely over the moon contributes to the weight on her shoulders. It could be too late before postpartum depression is noticed, manifesting in sleep disorders, mood and appetite changes, crying, difficulty concentrating, lack of interest in daily activities and spending time with the baby, and thoughts of death and suicide. PPD could even snowball into a condition called postpartum psychosis, another severe state of mind that is full of delusions and hallucinations that afflict the mother. Whether this is the case, or the mother is experiencing depression alone, both are emergencies that call for strict safety measures to be instituted immediately. Shockingly, PPD is responsible for 20% of maternal deaths in the course after giving birth, with fear of harming the baby in 36% of those cases and weak attachment to the child in 34% of cases (Ghaedrahmati et al., 2017).

How do such terrible statistics come into existence? The reasons for postpartum depression's occurrence and prevalence can only be roughly speculated by professionals. Sadly, the disease is just as unpredictable as any other ailment, but certain risk factors have been

identified as possibly contributing to the process. These factors fall into obstetric, psychiatric, social, and biological categories. Briefly explained, PPD risk factors include but are not limited to a history of mental disorders like depression and anxiety, reluctance related to the baby's gender, low self-esteem, having several children at home, hemorrhagic or prolapsed births, extremely young mothers (ages fifteen to seventeen years), hormonal changes, prenatal smoking, and relationship stresses (Ghaedrahmati et al., 2017).

Perhaps, women's health histories are not delved into sufficiently enough during antenatal and perinatal teaching, or women feel so consumed by the medical advice they receive that it feels like there is little room for dialogue about feelings and fears. This is a glaring problem, as pregnancy care should be thorough from the time before conception to months after childbirth. Medical professionals may be excellent at quieting clinical doubts with factual jargon, but minimal proof has been displayed across the discipline that providers, specifically obstetricians, are trained in allowing women to take ownership of their pregnancy experiences through free expression and one-on-one check-ins. This statement is not to blame healthcare providers our mark them as sufficient. Their work is extremely noble, and they work extremely hard to care for others. Yet, the reason healthcare is so advanced and admired is because it goes through constant change cycles which begin with speaking about noticed issues such as postpartum depression.

PPD is considered to be a "rare disease", and an excuse commonly used for why a standard of care is not established for it is that there is not enough money or there is not enough research about it. In later sections, I expand upon research that easily supports the need for PPD education, and the plausibility of low-cost options and volunteer-based help for hospitals. I also want to emphasize that any disease that affects families just as severely as individuals should not

be named rare; this is these people's lives that are ultimately unhinged due to a failure on healthcare's part, and revision is possible.

III. REVALENCE OF FEAR OF CHILDBIRTH

Women fall victim to postpartum mental complications for another big reason: fear of childbirth. Even for women who try for pregnancy and are successful, the happiness is more often than not accompanied by some level of fear. Not to mention, mothers who do not try or wish to be pregnant suddenly find themselves embarking on an overwhelming journey for nine or more months. Fear of childbirth may sound straightforward, but there is an abundance of reasons why a woman feels fear once she discovers she is pregnant. She may fear the unknown if she is a primigravid (or "first pregnancy") patient, or she could be afraid of repeating her own or others' adverse experiences or histories in labor. Not contrary to popular belief…women talk! And it is so easy when in a vulnerable position to subconsciously adopt reservations based on a loved one or close friend's trauma.

From H. Melender in 2002, a study of 329 pregnant women yielded an astounding 78% reported fear of childbirth. These fears could be related to the child or mother's wellbeing, interactions with healthcare staff, the looming possibility of a C-section, family life, or purely just the process of childbirth itself. C-sections are especially terrifying for those who have never had a surgery before in their lives. Whether all of these fears were the product of negative stories told by others, previous experiences in healthcare, the presentation of new and alarming information, or the introduction of a disease like gestational diabetes, the study showed a strong linkage between fear of childbirth and the incidence of postpartum depression. I bring this point up because fear of childbirth is a concrete phenomenon that can be pinpointed and solved early on in the pregnancy process, and that alone reduces the woman's risk of having PPD. Addressing

the struggle can begin with as simple a question as, "is anything worrying you at the moment?" By helping a woman come to terms with her fears and how she plans on coping with them, she already feels that much more supported on her journey.

IV. CURRENT GUIDELINES & ADVOCATES FOR PERINATAL CARE

From the eighth edition of the American Academy of Pediatrics' *Guidelines for Perinatal Care,* each phase of the perinatal period is discussed, and standards of quality and care are also identified. I wanted to talk about this journal because it helps form a picture of how women are being cared for today and what areas hold gleaming opportunity to be improved upon. In the section related to the postpartum period, there are subdivisions speaking to establishment of breastfeeding, ambulation (or mobility) recommendations, bed rest, diet, and anticipatory guidance like making the mother aware of deviations from normal and being prepared to respond to danger signs and symptoms. Anesthesiologist personnel are required at bedside to manage any anesthetic complications that can occur. Another important standard to note for the sake of this paper is that discharge from the delivery room or unit is at the discretion of the obstetrician care provider, and discharge is not complete until postpartum visit schedules are reviewed (American Academy of Pediatrics, 2017).

In this journal, a recommendation is made that mothers with mood disorders should be checked in with at their newborn's care appointments. There are a couple of problems I see with this suggestion. First, it excludes mothers who may not have a previous history of mood disorder from the luxury of this integrated option, and that opens the door for discrimination and makes those mothers all the more at risk without that support. Furthermore, if the infant is experiencing a health issue and the appointment's valuable time is being used to evaluate and initiate treatment for the baby, the mother is not going to want to focus on herself or talk about her

feelings. She will be far too preoccupied with the infant's wellbeing to deviate from the goal at hand. Plus, so much can happen in the time periods between newborn appointments. Continuity of care is a principle that needs to be practiced in every case, especially this one.

Luckily, what has been discussed in this argument is already in the forefront of some others' minds besides just the authors from the American Academy of Pediatrics. Many maternal mental health coalitions have popped up over the past four to five years, each reaching a different audience. From a 2022 Families for Depression Awareness interview with Joy Burkhard, the founder and executive director of *2020 Mom,* it is explained how one out of many nonprofit organizations is working to solve the silent maternal mental health crisis of this generation. Burkhard's organization strives for policies in the health delivery of expectant moms, tracks the progress that institutions across the country make, and identifies outside involvement in the health issue, such as the government's role. It has even started structured groups of mothers who advocate for federal policy changes. A multi-facetted organization such as this is really trailblazing the way for more recognition and effort towards PPD and maternal health. Joy says they have a "zero suicide" goal that they actively pursue each and every day. As more organizations like Joy's are being constructed, further steps are being taken towards that "zero suicide" goal.

V. THE NEED FOR NEW INTERVENTIONS

Most people have a built-in bias to discourage, dismiss, or disparage feelings that my indicate anxiety, repression, hesitancy, or sadness, especially after the baby is born. Self-recognition of this bias is the first step in creating short-term solutions that can later evolve into long-term ones. Preliminary, audits, mental health screenings, and hired maternal mental health advocates should be enacted. Again, these are short-term solutions to scaffold the building of a

new perinatal period. Hopefully, the nature of these allows them to be implemented in just a few months with the right accompanying attitudes.

For example, audits for communication and mental crisis recognition should be required of staff in the obstetric department annually, if they are not already held. This keeps the skill in the forefront of everyone's minds. Additionally, women should undergo mini mental health examinations in a series over the perinatal period and especially a day or two into the postpartum timeframe. Serial examinations pose a benefit because hormones and lifestyle alterations are constantly changing for the pregnant women and picking up on even the slightest change of demeanor is crucial. Next, if there is one thing that the previously mentioned Clancy case has taught me, it is that maternal mental health advocates are not given enough of a platform until a terrible tragedy strikes. Hospitals should consider the hiring of even just one maternal mental health advocate for their mother-baby departments, and right away there is space for someone specialized to make a big difference. It is likely they would even volunteer for the position, where pay and cost would not be a barrier.

With all of these interventions in place, however, it does not guarantee success in diminishing the issue of postpartum depression. Some hospitals may already do all of those things, and yet find themselves with consistently high maternal death statistics in the postpartum period, nonetheless. So, how can OBGYNs rethink their approach to the middle of the pregnancy period when the most physical and mental changes occur? In the first trimester of pregnancy, women are still enormously adjusting and figuring out their own perception of pregnancy, so that is an inadequate time to target an intervention. Obstetricians and midwives need to act in the sweet spot of pregnancy, the second trimester, when the mother has already spent months in this condition. Pregnancy becomes a routine, like any other thing in life, and once an expectant

mother has had the chance to develop her own routine, she is more likely to be open to moving into next steps.

New classes and educational sessions should be required as benchmarks of the second trimester. They would revolve around preparation for the postpartum period and spousal teaching for a positive and safe mental health environment for the mother and baby. These sessions may also include community networking to social support groups, cognitive behavioral sessions, or intensive discussion sessions with an obstetrician. There should also be an increase in education classes not about physical modalities but about psychological changes to expect during pregnancy and post-birth. The hope is that with this service, women and their partners would be able to fluently verbalize when to seek help from a specialist of a variety of fields (including psychiatry and social work), warning signs, abnormalities that may be wrongfully considered normal, and the mental changes that may seem strange but are completely acceptable with a new baby around.

As far as structure goes, these classes could alternate to be every other week with the physical labor instruction classes, or contrarily be on the same day as the physical labor classes as a more effective routine for some women who may have children at home and cannot be away from them multiple days a week. They could also be multiple times a week or just once a week, as the mother needs. It would all depend on her personal schedule and adapting it not to impede in her pregnancy but augment its health.

This is the beautiful thing about healthcare that should be preserved in all professions: transforming treatments and supports to best work for the individual client’s needs, not pushing a cookie-cutter intervention that may be effective in theory but is rejected by the lifestyle of one

particular person. The functionality of the woman should be maintained to support her mental health and tailoring a schedule to fit her lifestyle would help accomplish this.

More than just postpartum depression occurrence is on the line with absence of routine screening and true work for women's mental health during pregnancy. As has been clearly linked so far, mental health and physical health spheres cannot help but intersect. Fearful or at-risk woman may be at a higher risk for cesarean section (therefore, higher physical and psychological morbidity, reproductive scarring and body image issues, and higher cost of delivery with insurance stresses). Midwife psycho-education interventions have shown to reduce childbirth fear and improve birth outcomes for both the woman and the fetus. The psychoeducation sessions were scheduled at 24- and 34-weeks gestation and were self-scheduled over telephone for one-hour in duration. In these sessions, clients were allowed to review their current expectations and feelings around childbirth and any fears they possessed. The outcome of this trial was that experimental group women reported having less flashbacks than the control group of women, improved parenting confidence, a greater sense of autonomy, and an 8% lower rate of cesarean section, which improves the risk both mental and physical complications (Fenwick et al., 2015). Similarly, a study by Hassan in 2016 showed women with low-self-esteem related to their pregnancy who received intervention of structured or group education classes that networked parents together reported feeling better adjusted at six weeks postpartum. They also reported better coping skills and a greater enjoyment of mothering, with many requesting to continue the intervention far past the study's duration. These are great results.

As I mentioned previously, the mark of a successful solution is that it can be modified to fit into the woman's life without compromising the nature of the solution nor its benefit. In this study, it shows how women were in control of the scheduling and they were also the leaders of

the conversations that took place within the sessions. Having someone to raise confidence at regular intervals is so important, and the fact that mothers requested continuance of the intervention post-study portrays the optimistic impact it had on their lives.

I understand this will not be an overnight solution. Healthcare facilities have their structured programs and will not sway from those without compelling evidence, cost-effective proposals, and willing participants. The hope is that there can be a gradual introduction of new perinatal program designs in hospitals. OBGYN units can begin by trying one focused class for a handful of mothers and see the effects for themselves. As confidence in a polished intervention grows over time, even more classes with licensed professions can be offered to every expectant mother who walks through the doors of that one hospital. Maternal mental health advocates can spend a few days out of the week walking through the unit and offering their time.

And luckily, hospitals love learning from each other. It is why healthcare is so advanced. Once one institution takes the bold step and makes a change, it can be estimated that it will spread like wildfire. Bragging about good results is one thing businesses do best, and it will plant the seed for other places to want to have better outcomes. Through all of this, the wish is that labor and delivery professionals adopt a behavior of being less hyper fixated on the physical outcome and start taking the same measures and pouring the same energy given to physical outcomes to mental outcomes.

VI. CONCLUSION

When it comes down to it, all of the dreaming in the world needs to be consolidated to remember the root of it all: the women of today. Approximately one in five women have reported not being asked once about depression or anxiety during their prenatal or first trimester visit with an obstetrician. Over half of pregnant women who have depression listed in their

health histories say they were not treated at all during pregnancy, medically or otherwise (*Infographic: Identifying Maternal Depression | CDC*, n.d.). What a difference maybe one question would have made in those women's lives.

Blaming from others may come in the form of, "why did she not *say* she wanted treatment?" or, "she should have disclosed more if she was afraid." Going through the most tumultuous time of your life with your body forming a new human can make chronic illnesses like depression feel as though they need to take a seat on the back burner. Until, of course, it manifests in the most awful ways. Women are not superheroes, even though I would not mind calling them that with all they are able to do in pregnancy. They deserve the professional medical help that they pay for to help them realize what is equally as important to be treating along with the baby: themselves. The cliché is self-care is not selfish, and that is taught in schools all over the world. It needs to start being emphasized in women's care clinics all over the world.

There is truly a need for these new-age, second trimester classes and I do not think they are such a far cry from what hospitals offer for other departments, like telemetry workshops and CPR classes. Money and time are invested in those because of the purpose they serve to save lives, and supporting maternal mental health is no different. They may not even cost as much as those other existing classes require in materials. Giving mothers the chance to enhance their pregnancy and their mental health really centers around communication and connection to resources. That should not break the bank.

There is a new world that can be grasped with reformed action from all obstetricians. We can live in a world where husbands are not left fatherless and wondering what they did wrong, what they did not see but feel as though they should have. A world is reachable where no mother is

robbed of her rightful chance to fall in love with motherhood and raise children in a healthy and happy home.

If you are a woman reading this, or even a man who intends to have a wife carry his children someday, I wonder what scares you the most about the thought of it. There must be something, because I know I wonder how I am going to get through it someday, and what I would want available to me to ensure my wellbeing, my kids', and everyone else's around me.

I truly believe that there is hope on the horizon for expectant mothers if we use their pregnancy time to properly prepare them and appreciate that their mental health is no more perfect than anyone else's just because they are carrying a gift inside of them. Using that time to give proper education, counseling, and resources has made the difference for some, and can save a whole lot more. By cultivating a healthy body and a strong mind for a mother, we ensure her unequivocable right to a blissful future with her family.

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