

Caring for baby *and* mom

By Elizabeth M. LaRusso, M.D.

Early in my psychiatry residency, my first psychotherapy patient was Sally, an engaging young nurse-practitioner and new mother. She'd been referred by her physician husband, who could no longer deal with her tearfulness and "irrational" fears about dropping her infant daughter. For reasons I could only speculate about, Sally stopped coming to therapy shortly after beginning a treatment I'd thought was going

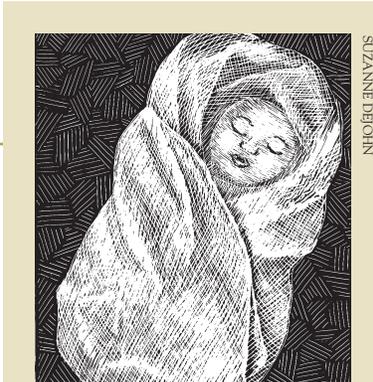
well. As I struggled to accept what felt like a loss, my wise and experienced supervisor shrugged and said kindly, "Psychotherapy is like that. We're able to read many books only halfway through."

I thought of Sally last week as I sat in a different, much nicer office, separated by five years and 100-plus miles from the cubicle in Boston where I first learned a lesson that I've encountered over and over in my work as a therapist. Alice, like Sally, was a health-care provider, a new mother, and someone I was drawn to; if we had met under other circumstances, I suspect we'd have been scheduling play dates rather than discussing the risks and benefits of Zoloft.

Unlike many of the patients I see in my work as a psychiatrist specializing in women's mental health, Alice had resources, a committed husband, and a sophisticated understanding of the health-care system. But like many of my other patients, Alice had been blindsided by postpartum depression. She had first come to see me a year earlier, after several weeks of worsening mood symptoms and escalating fears of crashing her car began to prevent her from leaving the house with her newborn son, Will. At that time, it was clear she was suffering a severe postpartum depressive episode, one that responded quite well to an antidepressant and increased support from her husband.

Pain: A year later, she was back to see me again, this time to better understand what she had gone through. "I always thought I'd have more than one child," she said, "but the pain of all those months I lost with Will is so fresh, I'm not sure I can do it again."

The practice of medicine reflects the values of society at large, and it's hard to escape the conclusion that as a culture we are more interested in women when they're carrying babies than after they deliver them. From my perspective as both a physician and the mother of a young child, postpartum women are a vulnerable and largely overlooked population. "Baby blues"—a syndrome characterized by tearfulness, mood instability, and anxiety—affects up to 80% of postpartum women but usually resolves within two weeks of delivery. Up to 20% of women, however, suffer postpartum depression. In these women, rapid identification and referral to a mental-health provider is crucial to the health and well-being of both mother and child. Yet



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the average American woman with an uncomplicated pregnancy sees her obstetrician weekly in the final stretch of pregnancy, then after delivery waits six weeks for a follow-up visit. This is not the fault of obstetricians, who are frequently overworked, disproportionately burdened by malpractice claims, and subject to unforgiving managed-care mandates; this is a consequence of a medical and societal infrastructure that prioritizes

the well-being of the baby over the needs of the mother.

Week after week in my perinatal psychiatry clinic, I see exhausted new moms; they are tearful, scared to sleep even when they can because of exaggerated worries about SIDS, unwilling to share the burden of nighttime feedings because of rigid self-expectations about breastfeeding. In addition, many are consumed by guilt that they're missing irreplaceable moments of their babies' lives.

Bliss: Having internalized society's expectations about maternal bliss, many new mothers see their depression as an unspeakable failure and thus are reluctant to seek help. Untreated maternal depression can interfere with mother-infant bonding, increase a child's risk of negative behavioral and emotional outcomes, and increase a child's vulnerability to psychiatric illness. In the weeks after giving birth, the average new mother experiences sleep deprivation, hormonal shifts, physical recovery, and practical and emotional adjustments to the demands of caring for an infant. Many a woman finds herself inadequately supported and lacking resources—such as mother's groups, parenting classes, and visiting nurses—that could help her navigate the dramatic shifts in her domestic roles and personal identity.

As I listened to Alice recount the steps she had taken to seek help—from her midwife to her primary-care doctor to a women's resource center to the psychiatry department, then back to her midwife and ultimately to my office, before getting an accurate diagnosis and treatment for her postpartum depression—I struggled to contain my emotions. As a physician, I was ashamed that the medical system had failed Alice; as a citizen, I was outraged that a society that lauds "family values" could be complicit in this neglect of postpartum women; and as a mother, my heart broke for what Alice and her son must have experienced during those dark first months.

Cause: Fortunately for Alice, she was able to advocate for and obtain the care she needed and deserved. Fortunately for women in the Upper Valley, the Dartmouth medical community—specifically via collaboration between the Departments of Psychiatry and of Obstetrics and Gynecology—is committed to improving the care of women who struggle with mental health issues; we have devoted significant resources toward this cause. And fortunately for me, having Alice return to my office to reflect on that chapter of her life has provided me with an opportunity to "read this book" all the way through. ■

The Point of View essay provides personal insight or opinion on some issue in medicine or science. LaRusso is an assistant professor of psychiatry and of obstetrics and gynecology at DMS. The names of patients have been changed to protect their confidentiality.