About the Authors

Perle Feldman, MDCM, FCFP, MHPE

Dr. Perle Feldman is an Associate Professor of Family Medicine at McGill University. She practices and teaches family medicine in Montreal.

Affiliations: McGill University Medical School faculty lecturer (clinical), Montreal, Quebec
Associate Professor, Family Medicine, McGill University, Montreal, Quebec

Judy Hagshi, MD, CCFP

Dr. Judy Hagshi is a dedicated family physician at the Herzl Family Practice Centre, affiliated with the Jewish General Hospital in Montreal, Quebec. Throughout her career she placed a strong emphasis on perinatal care. Recently she transitioned from catching babies to focus on enhancing the mental health of birthing individuals and their families. She is honoured to lead “The Fourth Trimester”, a multidisciplinary workshop series for Herzl patients, with plans to expand to other centres in Montreal and beyond.

Affiliations: McGill University Medical School faculty lecturer (clinical), Montreal, Quebec
Associate Professor, Family Medicine, McGill University, Montreal, Quebec

doi.org/10.58931/cwht.2024.1319

Hot Topics in Postpartum: Why the Six-week Visit is Outdated

Perle Feldman, MDCM, FCFP, MHPE
Judy Hagshi, MD, CCFP

Introduction

Gone are the days of the single six-week postpartum visit. Research has shown that healthcare, both physical and mental, must be more robust and comprehensive to adequately address the changes that occur and the ensuing challenges that transpire when welcoming a baby into the world.[1] In this paper, the words woman and mother include all pregnant people and those who give birth.

Why Should We Care?

Postpartum depression/anxiety/psychosis (which we will call Perinatal Mood and Anxiety Disorders [PMAD]) is very common. It occurs in 14–20% of women in high-income countries.[2] Of those pregnant people who get PMAD, one-third have pre-pregnancy psychiatric diagnoses, which can be exacerbated in the perinatal period. One-third develop PMAD during the pregnancy, and one-third present in the postpartum period, which can even extend to one year after birth.

PMAD is a disorder with a large spectrum ranging from "the baby blues" to postpartum psychosis. In recent years, it has become apparent that anxiety disorder may be even more prevalent than major depressive disorder.[3] Mortality in patients with PMAD is significantly higher than in their unaffected sisters.[2] The risk of death in the first year postpartum, primarily from suicide and accidents, carries a higher mortality than the risk of hypertensive disorders of pregnancy and postpartum hemorrhage combined.

Review of Three Cases

You are meeting three new prenatal patients in your clinic today.

Devi is a 20-year-old refugee claimant who just arrived in Canada and is in your clinic for her first prenatal visit at 26 weeks. The interpreter tells you she was forced to flee India because she and her husband married for love. When her husband's family found out that she was pregnant, they threatened her life and the baby. The refugee aid organization has arranged welfare and health benefits through the Federal Blue Cross program. Her husband cannot obtain a visa because of the current tensions between Canada and India. In your clinic, she is weepy and withdrawn.

The next patient is Martha, a 41-year-old litigation lawyer in a prestigious law firm. Her husband is a vice president of finance in a multinational business. They have been trying to have a baby for the past three years and Martha has undergone four cycles of IVF. She is now 12 weeks pregnant. She called for the appointment and asked if it was possible to come in before eight a.m. or after six p.m. After fifteen minutes in the waiting room, she asked your receptionist why you were late. On questioning, there is a history of endometriosis and anorexia as a teen. She is still very careful about her weight and fitness. Her husband joins the visit via Zoom from Paris, and they are thrilled to see their live active baby on point of care ultrasound (POCUS).

Finally (almost an hour late), you see Emily, a 29-year-old G2P1 with a 10-month-old baby you delivered. This pregnancy was unexpected, but Emily is happy to be pregnant again. Grateful to have a relatively simple visit, you hurry through it.

What Are the Risk Factors for PMAD in These Three Cases? How Can You Help Prevent its Development?

The most obvious risk factors are present in the first case. Devi is young, a new immigrant, socioeconomically vulnerable, has inadequate support, and will likely be a single parent.[4] Most importantly, perhaps, she is already depressed. In this situation the most appropriate thing to do is "call in the cavalry!" An immediate referral to social services, particularly those aiding refugee

claimants, is essential. They may help her find an ethical immigration lawyer to expedite her husband's admission to Canada. A referral to perinatal psychiatry/mental health services can be life-saving.

Martha also has multiple risk factors for PMAD. As an older pregnant person with a history of infertility, she is at higher risk.[4] Her personal history of anorexia nervosa may indicate that the bodily changes in pregnancy could trigger a recurrence of her psychiatric issues. Her personality and life experience have led her to believe that she can control everything, and this perfectionism can be a challenge when faced with the inherently uncontrollable nature of pregnancy, birth and the postpartum period.

To help protect her from possible PMAD, she should take some time to prepare for this pregnancy by participating in prenatal classes, ideally in a group setting where she could make contact with other pregnant women. She would also benefit by being referred to a reliable and trusted doula.[5]

Emily's risk factors are perhaps fewer than those of the first two patients, except for the unplanned pregnancy and a short interpregnancy interval.[4]

Other risk factors for PMAD include intimate partner violence, relationship dissatisfaction and LGBTQS+ identity. A personal history of mental health disorders and a family history of PMAD are also red flags. Nonetheless, risk factors are not the only important element in these cases: the perinatal period is an opportunity for primary prevention in psychiatry.[4]

Thirty-week Follow-up Visit

At the 30-week follow-up, you have some news to communicate to Martha. At 28 weeks, you were concerned that her symphysis-fundal height was not growing appropriately. An ultrasound has now shown her baby growing at the 8th percentile. The dopplers are normal. Her glucose tolerance test (GTT) is also positive.

You recommend that Martha decrease her workload from 60 hours/week and that she work from home when possible. You also inform her that she needs to be closely followed by the gestational diabetes and high-risk pregnancy clinic, which involves repeated visits and ultrasounds. Martha is distraught. This was not the plan! She bursts into tears in the office and leaves.

Devi, on the other hand, is looking much better than previously. The perinatal psychiatry team is following her. She has been placed on sertraline and is attending psycho-education groups. She attends prenatal classes at the community health centre and is linked with the public health nurse. She is obtaining food support from welfare and the community group she has joined.

She has met with an immigration lawyer. Although you have written letters supporting her husband's visa request, they are not optimistic he can arrive in Canada before the birth. Despite this, she smiles shyly during the visit. She "WhatsApps" with her husband while you examine her, and he is loving, supportive, and excited to see his baby on the ultrasound screen.

Emily is next. At her last visit, she complained about how exhausting her life was now that her baby was teething and waking her up at night. As she has not been able to return to work as planned, her husband has taken a second part-time job, and she is responsible for everything at home.

At her second trimester blood tests, her TSH, CBC and ferritin were checked. She was euthyroid, but her Hgb was 89 g/L with a ferritin of 5 mcg/L. It's no surprise that she was exhausted. You initially administered an oral iron replacement, which gave her constipation and cramps. You now arrange for IV iron, which should improve her fatigue. However, she is not the cheery person she was during her last pregnancy. You reassure her that the iron will help both physically and emotionally since optimizing the physical health of pregnant women can help prevent PMAD.[6]

Birth

Martha is the first to give birth. She has been working from home and has accepted that she must transfer many files to her home office. She is now taking insulin for her gestational diabetes. Her baby hovers around the 6th percentile, but the dopplers remain normal. At her 36-week visit, she complains of a headache with flashing lights in her vision. Her blood pressure is 150/95. Martha is diagnosed with HELLP syndrome with platelets of 45,000. Induction is initiated. Her husband Paul, who is in New York for a meeting, rushes to the airport.

After a few hours, her doctor decides to perform an emergency C-section because of recurrent decelerations. Martha's husband enters

into the labour and delivery room as Martha is being transferred to the operating room. He has many questions, but everyone is too busy to respond, and he receives very few answers. Martha is upset and somewhat confused but knows she needs to have this C-section now. The C-section proceeds and a 2.3 kg baby boy is born and transferred to the NICU. Paul is frightened to see how tiny and frail the baby appears and how hard everyone seems to be working on him. He was not prepared for the amount of blood and the seeming chaos. Once the baby is stabilized, the neonatologist and nurse debrief with him, and he proceeds to the recovery room to check on his wife.

Devi goes into labour at 39 weeks. She is accompanied in labour by her friend, who speaks some English. Her daughter is born after an uneventful labour. Devi is happy; her husband on the phone encourages her and supports her as much as possible from far away. She returns home with a plan for early follow-up visits from the public health nurse and follow-up by psychiatry. Her social worker has found her a place to live in a collective building for young mothers where she will receive support.

Emily arrives in active labour at 40 weeks, rushing through the door to triage, screaming. At her first examination she is 9 cm dilated with bulging membranes. Her water breaks and Emily delivers precipitously in triage into the hands of a medical student. She has a third-degree tear.

Postpartum

Emily is alone in her apartment. Her husband returned to work after only five days because his employer refused to recognize his paternity leave. In their precarious financial position, he cannot risk being fired. Her mother, who lives in another province, is still working but has arranged to take a two-week vacation in a few weeks to give Emily a hand. But for now, Emily is alone with her sixteen-month-old and her newborn. She is standing in her kitchen, leaking tears, milk, blood, and urine. Whenever she falls asleep, she is awakened by nightmares of her birthing experience, remembering how frightened she was. Like many in Canada now, she has no family doctor. Her postpartum visit is in four weeks.

Martha and baby Michael are now home. Michael spent a few weeks in the NICU. Martha worked very hard with the NICU lactation consultant to establish a milk supply. Michael has grown well but continues to require supplementary formula feeds. Paul has arranged for maternity nurses to provide nursing coverage both day and night because he is obsessed with the memories of how close he came to losing them both. He wonders if he is going crazy when he has flashbacks that awaken him from sleep.[7]

The night nurse encourages Martha to leave the baby with her "so she can get sleep and recover." Every time Martha awakens and goes to see Michael, the nurse says that she has just given him a bottle. During the day, she feels almost shut out as the nurse holds Michael the whole time. She feels incompetent. She starts thinking about going back to work soon because, at least there, she knows what she is doing. She is teary and lonely.

Devi is adjusting well to her new life. The support in her building complex is helping her learn skills as a mother. She has other people to talk to, and the mothers laugh and hold each other's babies. Soon, she can start language classes while her baby is cared for in the complex's nursery. She is happy, except for her deep longing to be reunited with the man she loves.

Antidepressants in Pregnancy

There is growing evidence that depression is harmful to the developing fetus. Having a depressed mother can cause epigenetic changes in the offspring that make them more prone to depression themselves and less socially open and communicative.[8] Researchers and clinicians alike realize that what happens in the womb can last a lifetime.[9]

Given the burden of PMAD in our society, the use of antidepressants in the perinatal period is well studied. Most currently used antidepressants are considered safe in pregnancy and breastfeeding. Sertraline and paroxetine have the least penetrance across the placenta and in breast milk. While some withdrawal symptoms have been reported, breastfeeding mitigates these effects as there is a naturally slow withdrawal as the baby grows.[10]

Zuranolone, a new drug that may change the way we manage PMAD, is available in the United States but is not yet approved in Canada.[11]

Discipline	Sample Topics
Nurse	Safe sleep routines, normal crying behaviour
Lactation consultant	Latch techniques, pumping/storing milk
Kinesiologist/physiotherapist	Pelvic floor health, diastasis recti exercises
Psychologist	Destigmatization, bonding activities
Social worker	Setting limits, self-identity
Pharmacist	Baby first aid, safe pharmaceuticals
Occupational therapist	Reactivation strategies, organizational tools
Nutritionist	Energizing foods, meal preparation strategies

Table 1. Model for multidisciplinary postpartum care; *courtesy of Perle Feldman, MDCM, FCFP, MHPE and Judy Hagshi, MD, CCFP.*

Multidisciplinary Care: Optimizing the Postpartum Course

Many experts now believe that postpartum care must be multidisciplinary to provide new parents with the skills, education and confidence to navigate the daunting task of raising a child in the modern world (**Table 1**).[1]

Why have things changed so much? The answer is twofold: first, we no longer live near or with extended family, where new parents absorb child-rearing skills by osmosis. Historically, parents welcomed new babies into multigenerational homes. These homes can be considered the prototype for a multidisciplinary support program.

In the above scenario, grandparents are awake in the middle of the night to help support a new mother or soothe a colicky baby. Aunts know the special care recipe to nourish a new mother and improve her milk supply. Cousins are great at occupying older siblings so the mother can rest. For some lucky new parents, a grandparent may move in for a few weeks, thus allowing the age-old practice of the 40-day postpartum confinement.[1] For many, however, there is no one to teach new mothers and fathers parenting skills due to minimal access to support services.

The second answer is more ominous. Life in the 21st century results in many parents entering parenthood with their own pre-existing challenges and vulnerabilities. While the incidence of PMAD is rising, so is the incidence of major depression in young adults before they even become parents. Setting up families for success right from the beginning has a cumulative effect on the family's life and beyond.

The links between poor coping and bonding at birth, to physical and mental health issues in the child, are well established.[9,12] Furthermore, when the birthing parent suffers from PMAD, the incidence of a depressive disorder is elevated in the partner, resulting in worse child outcomes.[3] We need to be careful not to blame parents for future health problems while realizing that breaking the cycle of depression and poor resilience can have effects that will echo down through generations.[8,13]

It Takes a Village

What should the postpartum evaluation encompass? Let's look at it from the perspective of a day in Devi, Martha, and Emily's lives. Babies require round-the-clock care, and poor parental sleep ensues. Emily could not ask too much of her husband during the overnight hours as he was

the only breadwinner and was already working two jobs outside the home.

While pregnant women are valued in our society, once the baby is born, new mothers take on enormous levels of responsibility with very little support. Implementing occupational therapy strategies such as prioritizing rest, outsourcing tasks, and restructuring routines can help ease the load.[14]

Many birthing women encounter breastfeeding difficulties. Martha had several strikes against breastfeeding success right from the beginning since she was separated from Michael while he spent time in the NICU. When a new mother cannot feed her baby or can only feed with pain, this reinforces the narrative that she isn't a good mother.[10]

We need to make lactation support easily accessible. Simple latch adjustments early in the postpartum stage can make an enormous difference in the long run. Furthermore, successful breastfeeding has even been postulated as a protective measure against PMAD.[10] Martha received these services in the NICU, but a lactation consultant who can provide latch adjustments should be publicly funded for everyone.[13]

Unfortunately, many women suffer from urinary control issues in the postpartum period[15] but do not address the issue directly with their healthcare provider. Both Devi and Emily were experiencing urine leakage every time they coughed or laughed. Given her language difficulties and shy nature, Devi couldn't even imagine discussing these issues with the other women in the complex. Emily was too isolated and overwhelmed and didn't know where to seek help.

The postpartum assessment must explicitly ask about and manage these incontinence issues. Ideally, the interventions of a provider adept in pelvic floor exercises would also be part of the prenatal care. But at the very least, support should be easy to access following delivery.[15]

The Ideal Scenario

Currently partners have more parental leave than in the past, but typically it lasts for just a few weeks. Eventually, the partner returns to their routine and the onus is on the birthing parent. If prenatal risk factors are present, the risk of PMAD is higher, but anyone and everyone is at risk. Many aspects of daily survival can be troubling, from interrupted sleep to integrating siblings and setting limits. All of these require psychoeducation and skills building.[1]

However, why should clinicians wait for symptoms? A structured support group comprising a range of clinicians providing evidence-based interventions[13] could prevent many incidents of PMAD and screen for severe disease. All of these primary prevention evaluations should be community-based, should not require heroic efforts to source, or cost enormous funds to realize.

The Fourth Trimester

Devi received extensive support from the public health nurse. However, Martha and Emily flew "under the radar" and were not targeted for supplementary intervention. Fortunately, a weekly postpartum psychoeducational group, dubbed "The Fourth Trimester" is being piloted at the hospital where Martha and Emily delivered. The group is run by a nurse practitioner adept at mental health interventions. Partners are welcome, and Paul joins Martha and Michael when he is in town.

Every week, a guest practitioner presents their area of expertise. The pelvic floor physiotherapist discusses incontinence and diastasis recti exercises. The lactation consultant monitors the participants and adjusts or supervises the latch. The psychologist discusses attachment theory and intergenerational trauma. The women learn together and from each other.

Conclusion

Building healthy families is an objective of women's health. Effective, structured postpartum care is a key to achieving that goal.

Correspondence

Perle Feldman, MDCM, FCFP, MHPE
Email: perle.feldman@gmail.com

Financial Disclosures

J.H.: None declared.
P.F.: None declared.

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Canadian Women's Health Today
Science for the Real World

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