

Postpartum Depression Leaves Families Helpless

By Sarah Lampson

Patient A has cancer. His wife does all the cooking and cleaning in their home and he has two supportive adult children nearby. Upon his diagnosis his family doctor referred him to a specialist for treatment and immediately had her secretary contact the local Community Care Access Centre. Within 48 hours a case manager called him to schedule homecare upon hospital discharge and ongoing homemaker support. At the hospital he is provided with accurate, up to date written medical information about his diagnosis and treatment. He meets with a social worker who provides information on support groups, financial assistance and community programs. Even after his need for nursing care is over, someone comes to shop, clean, cook, sit with him while his wife goes out and take him to appointments. He is still mobile, has a positive outlook, a rich social life and well managed pain. He did not have to demonstrate any particular need to get these services; they were indicated by his diagnosis.

Patient B develops post-traumatic stress and postpartum depression within a couple days of giving birth. Despite a documented history of anxiety and depression, she is not screened for PPD in the hospital. She has fourth degree lacerations and a spinal headache. With a newborn to care for and significant, inadequately managed pain, her midwife advises she lie flat on her back for 10 ten days. Although the patient requested breastfeeding support in hospital, none is provided. She requests the midwife help her at home and is told to go to a breastfeeding clinic even though she cannot lift her head or move without tremendous pain. The patient attends the clinic. She cries all the way there and home from pain. The patient is not only devastated about her inability to breastfeed, and the blame implied at the clinic for having a low milk supply, but she is crying

uncontrollably for hours a day. She contacts (sometimes repeatedly) her primary midwife, secondary midwife, family doctor, public health and a specialized psychiatry clinic for women and sobbing during the conversations explains she has PPD and needs help. Three times she is dismissed in person, visibly distressed. Three times she gets full voicemail boxes. Twice she is dismissed over the phone, audibly crying.

Family members cook her meals for three weeks after she returns from the hospital but her mood and pain reduce her appetite and she loses all 27 pounds gained during pregnancy less than a month after giving birth. Her extended family leaves, her husband cannot take a parental leave. All her friends work full time and are unavailable to help. Socially isolated and severely depressed with no treatment, she contacts public health, the VON, community services, a local hospital that has a homecare program, the early years centre and a breastfeeding clinic to ask for help finding childcare and homemaking help. Each time she explains, crying, she has PPD but no treatment and cannot cope with looking after a newborn. Every single agency advises her there are no programs available. All dismiss her without any apparent concern.

Patient B reviews the brochure on PPD she received as part of a standard hospital package for new mothers. The brochure refers to PPD as "an adjustment to motherhood" which is not only misleading but negates the seriousness of this catastrophic major illness. Overcoming PPD is not a matter of "adjusting" to parenthood like one does less sleep or less personal time. PPD must be addressed like other serious illnesses, with medical evaluation and treatment and comprehensive social services. The brochure states "You are not alone" but Patient B has never felt more alone; although she has

requested access to a support group from multiple agencies, there are none. The brochure also advises to "rest whenever you can" but with no support there is no rest. A well meaning but nervous first time father, her husband is reluctant to take the baby out on his own. He also is reluctant to leave his despondent wife even to go to work. He comes home every day at lunch to check on her and calls during the day. He too fails to access help.

Patient A is my friend. I am Patient B. I found a psychiatrist by emailing one I had previously seen for anxiety. My recovery from PPD was long and difficult even with medication.

Midwives are strong community advocates and my hope is that they will raise their voices, and encourage clients to raise theirs', to lobby for equitable, accessible healthcare for families affected by PPD. Midwives can start by critically reviewing client information sheets, attempting to arrange help for their clients directly and providing feedback to local service providers. Significant funds are invested in programs and people that are not fulfilling their mandates and there is a culture of unaccountability at many agencies, as I learned when I raised my concerns to them. As a society we are repeatedly, but I hope not consistently, failing women with PPD and the input of midwives will help us change this.

AUTHOR BIOGRAPHY

Having twice survived severe postpartum depression, Sarah Lampson frequently writes and speaks on both the illness and the system that almost defeated her. She is currently writing a book on her experiences. She lives in Hamilton, Ontario.