And a Mother Too

Noreen Mansuri

Writer's Comment: "And a Mother Too" is a case study I wrote for my UWP 104 course, Writing in the Health Professions. This assignment, as a reflection of the course's aim as a whole, allowed students to research and shed light on a medical topic profoundly interesting and important to them. As an advocate for improved women's health and aspiring OB/GYN, I was determined to discuss the painfully inadequate maternity leave policies within the United States using the experience of a strong woman I have known for years and am privileged by her willingness to be a part of this discourse, sharing some of her deeply personal experiences. From what I have observed and learned from other women, these experiences are not isolated or rare. For too long they have gone unaddressed and this case study is one of my first attempts to demonstrate this point as well as propel this topic into our national discourse for the purpose of change.

Instructor's Comment: The most compelling medical case studies—such as those authored by Oliver Sacks, Atul Gawande, and Lisa Sanders—use literary strategies to draw lay audiences into the life of single patient, but also leave readers with a sense of why this individual's story matters within a larger context. In "And a Mother Too," Noreen Mansuri balances these two requirements with the grace of a professional writer. Through the use of narrative arc, character development, and internal monologue, Noreen creates empathy for Simeen, a new mother suffering from postpartum depression. Like other effective case study writers, Noreen conscientiously conveys the physiological factors associated with this condition, but she also draws

a larger circle around Simeen's story, indicating the many ways in which the medical world and the professional world failed this young woman and exacerbated her distress. Consequently, Simeen's story has the potential to be the story of any new mother, and Noreen's case study overall offers a powerful call to action: to make those new mothers' stories less painful in the future.

—Melissa Bender, University Writing Program

Everyone had left and suddenly, the house felt empty. Her newborn baby was well fed and sleeping in the other room; all *seemed* to be well, but why did she feel as if everything were not? Sarah Aziz looked at her husband, Gabe, unable to tell him the debilitating anxiety that pinned her down with the weight of an elephant on her chest. She thought to herself, *this is what we have been waiting for, for so long. I am not supposed to be feeling this way. What is wrong with me?*

The next night, again after all the happy visitors had left, Sarah felt the same gripping and relentless anxiety. Gabe knew something was wrong when Sarah couldn't restrain her tears and bring herself to hold the baby. He held and comforted Sarah, trying to understand what was so clearly paining his wife. She tried to speak, but nothing came out. She did not know what to say, or how to say it—and was afraid of how awful it would sound out loud. Gabe knew Sarah had had an excruciating delivery, but after years of trying to have a baby, and a prior devastating miscarriage, the tiny girl in the crib next to them was their dream turned reality. It was only natural and appropriate they had named her Roya, which in Farsi means "*sweet dream.*"

The tears, anxiety, and fear became a part of Sarah's nightly routine. Yet she was unable to discuss them with anyone, not her husband, mother, or doctor, despite her many efforts to do so. She loved Roya and felt lucky to *finally* have her but was terrified that there was a being entirely dependent on her for survival. One night, as her mother was about to return home, Sarah couldn't let her walk out of the door: "Don't leave, I don't want you to go." Her mother was most willing to stay but shocked. Sarah had always been so resourceful and independent. She started working at sixteen, secured funding for her bachelor's degree, and paid for her own master's. At only 23, she had become a Speech-Language Pathologist (SLP) and, after working as a health-care professional for the

last four years, seemed well-equipped to handle any issues related to her pregnancy and delivery. Her mother had not seen Sarah this anxious since she was in high school suffering from depression during her divorce from Sarah's father. She knew something was wrong.

Still confused and overwhelmed by her feelings, Sarah tried to distract herself. While she was at home, she would turn on the TV and listen to shows playing in the background as she picked up the house and cleaned the baby's clothes and bottles, preparing everything for when Roya woke up from her nap. Then, one commercial abruptly broke through Sarah's distracted, think-while-you-work internal discourse, directing her attention to the TV. "Do you have symptoms of postpartum depression? Contact your doctor today." A wave of relief washed over her exhausted body. *That's it. I have postpartum depression.* She could breathe more easily with this accidental discovery. *I can deal with this. This is normal.*

Classified as a major depressive disorder (MDD), postpartum depression (PPD) appears within one month after childbirth and is attributable to the dramatic changes in hormone levels following delivery [1]. It affects approximately 15% of women in the United States and is different than the "baby blues," a milder condition marked by mood swings and fatigue that can increase a woman's likelihood of developing postpartum depression [1]. Although postpartum depression impacts a significant number of new mothers, it is undertreated and underreported for several reasons. First, there are low screening rates of PPD by clinicians who, lacking sufficient knowledge, training, and resources in mental health services, do not feel confident in diagnosing or treating psychiatric conditions. Second, many women struggle to initiate conversations regarding their depressive feelings in light of popular anecdotes and expectations of motherhood as an exultant experience [1].

Sarah was confident she was experiencing postpartum depression. Although she had battled with depression as a teenager, she had not been able to identify her current condition because it felt much more extreme and debilitating than anything she had encountered before. Not only had her feelings seemed novel and strange, but Sarah had not been prepared for the possibility of experiencing depression during or after her pregnancy. Her obstetrician/gynecologist (OB/GYN) had never once spoken to her about it. *The only thing he talked to me about during my visits leading up to the delivery was my birth plan! Would I want the epidural or not?* As an educated individual, Sarah felt that with this diagnosis she

could now take steps to help herself deal with her depression. Most importantly, she felt validated that her emotions were *normal*. This gave her confidence to speak to her husband and mother about it—but not her doctor, who had not taken the time to inform her, his patient, of the possible complications after pregnancy. She was further deterred from seeking his assistance after his continued lack of initiative, receptiveness, and concern in numerous instances after her pregnancy, adding to the difficulties she was already experiencing.

Many factors can contribute to a woman's likelihood of developing postpartum depression including a history of depression, stressful life events during or after pregnancy, and/or medical complications during or after childbirth [2]. Therefore, it is important to discuss postpartum depression with pregnant mothers, especially those who may be at higher risk of developing it. The diagnosis and treatment of postpartum depression is not only vital to the mother's mental and emotional health, but also to infant development which is influenced by mother-infant interactions [1]. Infants of mothers with PPD show higher rates of stress, excessive crying, sleep problems, and poorer self-regulation [1].

Sarah, unknowingly, had been at increased risk for postpartum depression not only because of her past depression but for several other concurrent stressful medical and life events as well. During her final days of pregnancy, Sarah began to feel extreme and persistent itchiness. Concerned, she immediately called her doctor to schedule an appointment. Sarah worried she had cholestasis, a liver condition that appears late in the third trimester, that disrupts the mother's ability to absorb fats, and is often associated with itchiness. For the developing baby, this condition can be detrimental, in the most severe cases leading to fetal death [3]. After discussing her symptoms, Sarah's doctor did not express concern and assured her topical Benadryl would suffice. Sarah heeded her doctor's advice, but the discomfort did not subside until the next time she found herself in the hospital on the day of her delivery. While the nurses were preparing Sarah for her delivery, they ordered a blood test to anticipate any possible complications. Sarah's contractions had increased in intensity and frequency, she was in labor, and the baby was coming when nurses solemnly informed her she had cholestasis. There was not enough time between the diagnosis and delivery to process the information she had just received. All she could do and all she wanted to do was deliver her baby. It was not until later it hit her. *That could have*

killed my unborn child.

Roya was born a healthy baby, but Sarah and her nurses were concerned when she would not latch on to breastfeed. Sarah was determined to breastfeed her daughter and rely on formula only as a last resort. When she returned home, she had a lactation specialist come help Roya latch on. They attempted several different maneuvers but none of them seemed to work. Then, suddenly, Sarah's efforts encountered another roadblock. Breastfeeding was growing excruciatingly painful. Her breasts were tender, red, and swollen. She developed a fever. She had almost all of the symptoms of mastitis, a breast tissue infection that is common during breastfeeding and treatable with antibiotics [4]. At the recommendation of the lactation specialist, Sarah called her OB/GYN for antibiotics. Unconvinced, however, he did not prescribe her any since she was not exhibiting *all* of the symptoms of mastitis. Despite this, Sarah continued to breastfeed through the pain until the infection spread too far and the pain was unbearable. Her husband rushed her to her primary care doctor, who immediately diagnosed her with mastitis and prescribed her antibiotics. For Sarah, the pain was not the most upsetting aspect of the experience, but the inability to breastfeed her daughter. The anxiety she had already been feeling was even worse. *I am the source of all of my daughter's nutrition.* Later on, Sarah explained, "It makes you feel like a failure when you cannot nurse your child."

In the midst of her health issues, Sarah made yet another alarming discovery. She had been dropped from her insurance. A few months prior to her delivery she had sought out assistance through her employer to add Roya to her insurance. For some reason, the paperwork had never been submitted and she was without coverage as well. Sarah urgently began the process of transferring the whole family under Gabe's insurance. On maternity leave, Sarah could not count on her income to cover any additional medical costs that should arise. Through her work, she had fourteen weeks of maternity leave with only 50% of her regular pay. Her husband's paternity leave was hardly better with 60% of his regular pay.

The United States is the only developed nation in the world without guaranteed paid maternity leave [5]. According to the 1993 Family Medical Leave Act (FMLA), men and women are guaranteed *up to* 12 weeks of *unpaid* leave following the birth of a child or death of a family member [5; my emphasis]. To qualify for FMLA, an individual must have worked at least one year at a company with fifty or more

employees [5]. In California specifically, employers are not required to pay employees during maternity leave, but pregnant women can qualify for disability under the California Pregnancy Disability Law (PDL) to reclaim a portion of their salary while on leave [6].

Outside of the maximum 12 weeks of leave, American parents do not have many options available to them should they wish to spend more time with their newborn children. For her second daughter, born two years after Roya, Sarah was given only six weeks of partially paid leave. She requested six additional weeks, which her employer granted her, but *entirely* unpaid. It was difficult for Sarah to decide to take the additional six weeks off without pay because she needed her income. *I have to choose between lifestyle and being a mom*. She boldly chose to be a mother, but that should not be interpreted as a reflection on how she prioritizes her career. Sarah is dedicated to her profession and has made significant contributions to her field as the creator of several innovative treatment plans for the patients she treats as an SLP. But without services that cater to her needs and responsibilities in her dual role as a Speech-Language Pathologist *and* mother, she finds it hard to make the desired progress in her career without sacrificing family. This is a struggle familiar to many women.

Given that 15% of women are affected by postpartum depression, and like Sarah, are juggling multiple other medical and life issues, they must be provided stronger medical care. Obstetrician/gynecologists should discuss possible postpartum complications with all of their patients as a standard of care and screen for postpartum depression in follow-up visits. This will require additional mental health training for doctors and effectively validate the reality of PPD so that it is not as underreported and undertreated. Such improvements in clinical care must be coordinated with employer services. Employers should be prepared to offer their female employees adequate length and fully paid leave to ensure they have the necessary amount of time to recover from their delivery with no added stresses of uncertain income or insurance coverage. Had Sarah been informed about her potential for developing postpartum depression, she could have better prepared herself to confront and treat it. Instead, she never received any medical attention for PPD and relied solely on the support of her family. Had Sarah received the necessary services from her employer, she would have been able to focus on her own health and possibly recover sooner.

The presence of women in the work force does not directly translate to equity and equality between the sexes. Most women will become pregnant at some point in their careers and should not be concerned about the impact on their employment or quality of life. The responsibility to support female members of the work force falls upon clinicians and employers alike. The potential for pregnancy should not be considered an additional cost to employers, but a natural responsibility on behalf of their female employees. As citizens, we must demand the political will to protect our mothers in the work force and to enact policies that will acknowledge the additional medical issues they face by providing them with the resources and time to care for their families and for themselves.

References

1. Pearlstein T, Howard M, Salisbury A. Postpartum Depression. American Journal of Obstetrics Gynecology. 2009; 200(4): 357-364.
2. National Institute of Health. Postpartum Depression Facts. No.13-8000. https://www.nimh.nih.gov/health/publications/postpartum-depression-facts/index.shtml. Accessed 4 March 2018.
3. The Mayo Clinc. Choleostasis of Pregnancy. 2018 https://www.mayoclinic.org/diseases-conditions/cholestasis-of-pregnancy/symptoms-causes/syc-20363257.
4. The Mayo Clinic. Mastitis. 2018. https://www.mayoclinic.org/diseases-conditions/mastitis/symptoms-causes/syc-20374829. Accessed 4 March 2018.
5. The Lancet. The future of paid family leave in the USA. 2014; 384(9937): 2.6. Maternity Leave California. Brangian Robertson. 28 January 2017. https://brobertsonlaw.com/maternity-leave-california/.