American Journal of Biomedical Science & Research

www.biomedgrid.com
ISSN: 2642-1747

Opinion

Rethinking Postpartum Care: A Call for Expanding the Scope Beyond Abdomen and Pelvic Floor

Tomás Bonino-Covas*, Sara Cañamero-de-León, Elena Márquez-Segura

Independent Researcher, Madrid, Spain

***Corresponding author:** Tomás Bonino-Covas, Independent Researcher, Madrid, Spain.

To Cite This article: *Tomás Bonino-Covas*, Sara Cañamero-de-León, Elena Márquez-Segura. Rethinking Postpartum Care: A Call for Expanding the Scope Beyond Abdomen and Pelvic Floor. Am J Biomed Sci & Res. 2026 31(2) AJBSR.MS.ID.004024,*

DOI: 10.34297/AJBSR.2026.31.004024

Received: May 12, 2026; **Published:** May 28, 2026

Abstract

Postpartum rehabilitation has traditionally focused on the abdominal wall and pelvic floor, potentially overlooking the broader context in which recovery occurs. The postpartum period represents a complex life transition involving sleep deprivation, increased mental load, emotional changes, and variable social support, all of which can influence recovery, pain perception, and adherence to treatment. This paper highlights the limitations of a purely tissue-centered perspective and emphasizes the need to integrate contextual factors such as stress, fatigue, nutrition, hydration, and caregiving demands into clinical reasoning.

It advocates for an expanded clinical approach grounded in the biopsychosocial model, which reframes low adherence as a context-dependent outcome rather than a lack of motivation. This approach requires expanding the scope from a single discipline, to coordinated interdisciplinary care, where all healthcare providers contribute complementary perspectives to support recovery within the woman's real-life context. The article elaborates how this approach involves adapting interventions to real-life constraints and addressing key determinants of recovery beyond physical structures, which may enhance the effectiveness and sustainability of postpartum rehabilitation outcomes. It concludes operationalizing this approach with actionable strategies useful to implement this broader clinical approach for all health professionals related to postpartum women.

Introduction

There is a scene that repeats itself every day in our clinics: a woman arrives and lies down on the treatment table. She has given birth weeks or months ago—sometimes years. She tells us about urinary leakage, a feeling of vaginal heaviness, low back pain, a belly she no longer recognizes as her own. We assess. We observe the linea alba. We measure the diastasis. We palpate the pelvic floor. We talk about activation, the transverse muscle, motor control. And while we focus on her abdomen and her pelvic floor, we stop looking at her, as a whole being, at her context, her practices, her life. The abdomen and the pelvic floor have become the literal and symbolic center of treatment for the abdomino-lumbo-pelvic complex. We measure them, photograph them, analyze them [1-3]. But these body parts do not raise babies, do not sleep in fragmented three-hour stretches, do not hold a household together, do not carry the guilt of not being able to do everything, do not suffer from the lack of real support from partners and surroundings. The abdomen and the pelvic floor are not in survival mode. That woman is. If we want to transform women's recovery, we must first transform the way we see them.

A Treatment That Remains at the Level of Tissue Runs the Risk of Becoming Blind

For years, we have refined our techniques. We know more than ever about deep activation, intra-abdominal pressure, load progression, and fascia. And all of that is valuable. It is necessary.

It is part of the treatment. But it is not the whole treatment. Not the truly valuable part. When we reduce recovery to a matter of millimeters of abdominal separation or strength on the Oxford scale, we are simplifying an experience that is infinitely more complex. Tissue matters. Biomechanics matters. But no bodily structure exists independently of the context in which it lives—the ecosystem in which it develops.

The Biopsychosocial Model is not a Theoretical Embellishment; It is A Clinical Responsibility

We speak at length about the biopsychosocial model. We cite it in training courses, teach it in master's programs, defend it at conferences. But when a woman walks into the clinic, we often revert to the most classical biomedical model: identify deficits, analyze anatomy, assess pressure management, prescribe exercise, review progress. Where does the social dimension go? The emotional? The relational? We cannot talk about pain without talking about stress. About tissue recovery without talking about rest. About fascia and the linea alba without talking about hydration. About exercise without talking about nutrition. We cannot talk about many other things without addressing mental load, fears, support networks, uncertainties, disappointments, and frustrations.

The postpartum period is not just a physiological event; it is a life upheaval. The body changes, yes—but so do identity, the couple's relationship, the household economy, the time available, and the place a woman occupies in the world [4-6]. And yet, in clinical practice, we often treat postpartum as if it were only a biological process of tissue repair. The woman who comes to see us may be experiencing several—or sometimes all—of these situations: sleeping only a few fragmented hours each night, eating quickly and poorly, sustaining breastfeeding under extreme self-imposed pressure, managing infant care alone, trying to perform at work as before, feeling guilty for not enjoying every second, not hydrating adequately, and experiencing a level of stress she has never known before [7-10].

Recovery and Tissue Adaptation do not Occur in Isolation

And the reality is that the nervous system is absolutely exhausted. And we know very well that a nervous system in a state of constant alert does not learn the same way. It does not repair the same way. It does not tolerate loads the same way. Chronic sleep deprivation alters pain perception, increases cortisol, reduces recovery capacity, and makes adaptation to exercise more difficult [11-13]. We can prescribe the best program in the world. We can explain every contraction in detail. But if the woman is living in survival mode, the body is not in recovery mode. It is not a lack of adherence. It is not disinterest. It is not that she "doesn't activate properly." It is exhaustion. And exhaustion is not corrected with exercises alone, manual therapy, ultrasound, needles, and kind words. Adherence to rehabilitation programs is strongly influenced by contextual constraints, including time availability, caregiving demands, and perceived support. Low adherence should not be interpreted solely as a lack of motivation, but as a reflection of the interaction between the intervention and the individual's life context.

When the Basics of Health are not in Place, Let's Adapt Without Blaming

It is very common for us to forget, as an essential part of the help we can offer, to address the often-overlooked foundations: sleep, hydration, and nutrition. We become obsessed with activating the transverse muscle while the woman barely drinks water throughout the day. We talk about tissue regeneration while her diet is insufficient and disorganized. We seek muscular performance in a body that does not rest. Tissue needs substrate. Muscle needs energy. The nervous system needs pauses. Without sleep, without adequate hydration, without minimally sufficient nutrition, recovery becomes an uphill battle. And not because the body is failing, but because we are ignoring its most fundamental bases. We know that, many times, it is not possible for this woman to improve these three areas—at least for a while. If that is the case, let us not be the ones who add more burden to that system, nor expect to obtain impossible results from someone in those conditions.

A Support Network is also a Prognostic Factor

On the other hand, we know that women who have a strong support network—family, friends, community—tend to show greater adaptability, better emotional regulation, and higher therapeutic adherence [14]. It is no coincidence that support reduces burden. With less burden comes less stress. And with less stress, both pain and recovery improve. Asking "Who helps you?" should be part of the initial assessment, with the same naturalness as asking about urinary leakage. For all these reasons, it is very important, in the management of postpartum women, to broaden our perspective. And broadening our perspective does not mean abandoning the technical side.

It is not about stopping the assessment of diastasis. It is not about ignoring the pelvic floor. It is not about giving up technical rigor. It is about integrating that woman's ecosystem, because technique without context is incomplete, exercise without life analysis is limited, and strength without rest is fragile. The next time you assess a patient, don't start with her abdomen or pelvic floor. Start with her life [15,16].

The Lack of Shared Responsibility as a Structural Life Burden

Let's talk now about something uncomfortable to bring up in the clinic, yet essential and fundamental in the postpartum process and experience: shared responsibility and the distribution of duties at home—or rather, the lack of it. Many women come to consultation completely overwhelmed. Because, in addition to the new situation brought by the arrival of a new life, they care,

organize, anticipate, remember, plan. They carry the emotional and practical logistics of the family. They manage, work, and provide. The level of mental load is extremely high [17-19]. And us, as health professionals, expect them, on top of that, to perform demanding exercises that, moreover, do not fit into their lives (increasing the sense of guilt and "lack of commitment" for not doing them). If their partner does not truly share tasks and caregiving, if there are no real spaces and times for rest, if they cannot delegate without guilt, then everything we do, suggest, or prescribe will do nothing more than add to the burden [20,21]. Talking about shared responsibility is not activism in the clinic. It is recognizing a variable that directly impacts functional recovery.

From Awareness to Clinical Action: Operationalising a Broader Clinical Approach

Expanding our perspective is not only about thinking differently, but about acting differently in clinical practice. This requires moving from general awareness to structured, intentional interventions that integrate the woman's context as a central component of care. The effectiveness of rehabilitation is not only a matter of what is prescribed, but of what the patient is realistically able to integrate into her daily life. As a primary care center (understood as the first line of healthcare for the community, whether publicly or privately managed), we must be able to offer tools that help address the common problems of the community we serve.

Several practical strategies can support this shift:

a. Integration of contextual screening into the initial assessment

Beyond physical examination, systematically explore sleep quality, perceived mental load, availability of social support, and real daily time constraints as part of clinical reasoning.

b. Integrate the program into everyday life routines. Don't push so much for a dedicated time to do exercises. That won't happen often.

c. Using dose reduction as a therapeutic strategy

In highly stressed systems, reducing the volume or intensity of intervention can facilitate adherence, improve tolerance, and support recovery.

d. Create clinical spaces that allow rest, not only performance

Incorporating moments that prioritise downregulation, pause, and recovery, recognising the role of the nervous system in adaptation.

e. Also include some minutes at the beginning of the session to bring presence and feel here (and "me" again just by focusing on me); and conclude sessions with moments of relaxation, and gratitude to the self – some might even snore here, which would be wonderful!

f. Shift the focus: from "educating" to "facilitating"

Instead of giving lists of "shoulds," use prompts like: "How can we make drinking water as easy as possible?" "What quick option could you have when you don't have 10 minutes to cook?" Integrate this into your clinical reasoning, not as a standalone piece of advice.

g. Facilitate peer support and community connection

Prome interaction with other women in similar situations to reduce perceived burden and enhance engagement. Promote group creations, communications etc. in group-sessions. Even a whatsapp group could be a key component for adherence.

h. Address co-responsibility as a clinical variable

Exploring how care tasks and responsibilities are distributed within the household, recognising their direct impact on recovery potential. Education to partners should be considered to understand the need of co-responsability not just as "help" but as a need for physical and mental health of the mother. Also help them to map the activities and actions that need to be shared and organized differently

i. Reframe adherence as a context-dependent outcome

Understanding adherence as a dynamic result influenced by environmental, emotional, and social factors, rather than an individual trait. Normalice variability in the application of prescribed activities, analize together the contexts and moments that allows and the ones that limits the chances to do them and change the language about adherence (from "if you are not consistent you will not get better" to "let's see what made it difficult last week") are examples that could be used.

j. Eliminate blame-based language

Phrases like "if you don't eat well, you won't improve" or "you should take better care of yourself" should be replaced with possibility-oriented, non-blaming language suchas: "In this moment of your life. Where do you think there might be a little space for you?" or "What kind of movement would be easiest for you right now?"

k. Facilitate access to meal delivery services

Given that food-related tasks represent a substantial portion of both cognitive load and time demands in the postpartum period—including planning, shopping, organizing, and preparing meals, for those who can afford it, outsourcing this responsibility could significantly reduce daily burden, freeing up physical and mental resources for recovery and self-care.

These approaches do not replace technical expertise; they expand it. They allow us to move from treating isolated structures to supporting the woman as a whole system. Probably many other actions can be implemented to support mothers in the various aspects of their lives that are affected during the postpartum period. It will be up to each professional and their community to find the best ways to provide more meaningful and realistic

support. In many cases, the limiting factor is not the muscle, but the life surrounding it

Conclusion

Postpartum rehabilitation cannot be reduced to the treatment of isolated structures and should evolve toward a more comprehensive and biopsychosocial model that consider context and lived reality of the woman at this stage in life. Moving forward, healthcare practice must embrace the complexity of the whole postpartum experience and translate it into actionable clinical strategies. Technical expertise remains essential, but its impact depends on its integration within the lived reality of each patient. A broader clinical perspective is necessary to support meaningful and sustainable recovery outcomes. Rather than expanding the scope of a single discipline, this model is based on coordinated interdisciplinary care, where all healthcare providers contribute complementary perspectives to support recovery within the woman's real-life context.

Conflict of Interest

None.

Acknowledgement

None.

References

1. Benjamin DR, van de Water AT, Peiris CL (2014) Effects of exercise on diastasis of the rectus abdominis muscle in the antenatal and postnatal periods: a systematic review. Physiotherapy 100(1): 1-8.
2. Bø K (2004) Pelvic floor muscle training is effective in treatment of female stress urinary incontinence, but how does it work? Int Urogynecol J Pelvic Floor Dysfunct 15(2): 76-84.
3. Manzotti A, Fumagalli S, Zanini S, Brembilla V, Alberti A, et al. (2024) What is known about changes in pelvic floor muscle strength and tone in women during the childbirth pathway? A scoping review. Eur J Midwifery 2: 8.
4. WHO (2022) WHO recommendations on maternal and newborn care for a positive postnatal experience. *https://www.who.int/publications/i/item/9789240045989*
5. (2021) NICE Guideline NG194. Postnatal care up to 8 weeks after birth. *https://www.nice.org.uk/guidance/ng194*
6. Gui Z, Liang Y, Huang Y, Gu Q, Li Q, et al. (2026) Barriers and facilitators to pelvic floor muscle exercises among postpartum women: A meta-synthesis based on the capability, opportunity, motivation, and behavior (COM-B) model. Midwifery 153: 104695.
7. Stewart DE, Vigod S (2016) Postpartum depression. N Engl J Med 375(22): 2177-2186.
8. Rai S, Pathak A, Sharma I (2015) Postpartum psychiatric disorders: Early diagnosis and management. Indian J Psychiatry 57(Suppl 2): S216-21.
9. Jackson L, O Donoghue E, Helm J, Gentilcore R, Hussain A (2024) 'Some Days Are Not a Good Day to Be a Mum': Exploring Lived Experiences of Guilt and Shame in the Early Postpartum Period. Eur J Investig Health Psychol Educ 14(12): 3019-3038.
10. Georgia Constantinou, Sharon Varela, Beryl Buckby (2021) Reviewing the experiences of maternal guilt – the "Motherhood Myth" influence. Health Care for Women International 42(4-6): 852-876.
11. Celi Yang, Xiaona Na, Haibing Yang, Menglu Xi, Yucheng Yang, et al. (2025) Maternal sleep and psychological status in the postpartum period are associated with functional protein alterations in breast milk: a mother-infant cohort study. Clinical Nutrition ESPEN 67: 510-522.
12. Jones PAT, Ruchat SM, Khan Afridi Z, Ali MU, Matenchuk Ba, et al. (2025) Impact of postpartum physical activity on maternal sleep: a systematic review and meta-analysis. Br J Sports Med 59(8): 576-583.
13. Young Lin N, Heneghan C, Liu Y, Schneider L, Niehaus L, et al. (2025) Insights into maternal sleep: a large-scale longitudinal analysis of real-world wearable device data before, during, and after pregnancy. EBioMedicine 114: 105640.
14. Sebela A, Horakova A, Nemcova H, Kuklova M, Noskova E, et al. (2025) Mom Supporting Mom: Effective Peer Support Intervention for Women with Postpartum Psychological Distress. Psychosocial Intervention 34(3): 151-160.
15. Toledo C, Quidley Rodriguez N, Cianelli R, Villegas Rodriguez N (2025) A Qualitative Study of Postpartum Women's Lived Experiences During COVID-19. J Midwifery Womens Health 70(2): 308-314.
16. Akselsen HM, Leknes EH, Engen T, Vik ES, Nilsen ABV (2023) Midwives' experiences with providing home-based postpartum care during the COVID-19 pandemic: A qualitative study. Nursing Open 10(11): 7333-7342.
17. Arendell T (2001) The new care work of middle class mothers: Managing childrearing, employment, and time. Minding the time in family experience: Emerging perspectives and issues 3: 163-204.
18. Daminger A (2019) The cognitive dimension of household labor. Am Sociol Rev.
19. Aviv E, Waizman Y, Kim E, Liu J, Rodsky E, et al. (2025) Cognitive household labor: gender disparities and consequences for maternal mental health and wellbeing. Arch Womens Ment Health 28(1): 5-14.
20. Leahy Warren P, McCarthy G, Corcoran P (2012) First-time mothers: social support, maternal parental self-efficacy and postnatal depression. J Clin Nurs 21(3-4): 388-397.
21. Sosa Páez, Valeria, Kamenetzky, Giselle, Rovella, et al. (2023) Effects of perceived social support on maternal stress and breastfeeding: A narrative review. Interacciones 9: e334.