# Perinatal Mood Disorders (PMD) Video – Pre-test

best start
meilleur départ

by/par health nexus santé

**Name:** _____
**Title:** _____
**Agency:** _____

1. **I feel confident in my ability to recognize, assess, support and treat (where applicable) women with PMD in my practice:**
   ○ very confident ○ moderately confident ○ not very confident ○ not at all confident

2. **PMD can be distinguished from PP blues by the:**
   - ○ Coping ability of the woman
   - ○ Severity of symptoms and lack of improvement within two weeks
   - ○ Lack of improvement by 6 weeks postpartum

3. **Mood or anxiety disorders during pregnancy**
   - ○ Occur at a rate similar to post partum mood disorders
   - ○ Are not common, because pregnancy is a protective factor
   - ○ Occur frequently due to pregnant women's inclination to worry

4. **The top reasons why women with PMD are under diagnosed and under treated are:**
   - ○ The knowledge and attitudes of care providers
   - ○ These conditions are self-limiting and women will recover on their own
   - ○ Lack of treatment options and lack of research of effective treatments

5. **The most commonly used tool to screen for PMD is:**
   - ○ The Beck Depression Inventory
   - ○ The Edinburgh Postnatal Depression Screen
   - ○ The Alpha tool

6. **Interviews should assess for sleeping difficulties because**
   - ○ Pregnant and new mothers don't sleep much
   - ○ Sleep deprivation can greatly increase symptoms
   - ○ Getting 6-8 hours of continuous sleep at night is essential for recovery

7. **When women share that they have ruminating thoughts or intrusive images, health care providers should:**
   - ○ Assess the client for risk of harming herself or her infant
   - ○ Involve child protection services
   - ○ Have the client admitted to the nearest psychiatric unit

8. **Effective treatment for PMD are:**
   - ○ Medications, nutrition and exercise
   - ○ Counseling and parenting classes
   - ○ Medication, counseling and support

9. **Women at risk for bipolar disorder or psychosis**
   - ○ Should be treated with antidepressants because counseling is not enough
   - ○ Should have child protection services involved
   - ○ Should be assessed carefully and may need mood stabilizers or anti-psychotics

# Perinatal Mood Disorders (PMD) Video – Post-test

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**Please send my certificate to the following address:**

_____

_____

# Life with a new baby is not always what you expect.

## 1 in 5 mothers will have a postpartum mood disorder.

**Have you had some of these symptoms for more than two weeks? You may:**

- ☐ Not feel yourself
- ☐ Be sad and tearful
- ☐ Feel exhausted, but unable to sleep
- ☐ Have changes in eating or sleeping pattern
- ☐ Feel overwhelmed and can't concentrate
- ☐ Have no interest or pleasure in activities you used to enjoy
- ☐ Feel hopeless or frustrated
- ☐ Feel restless, irritable or angry
- ☐ Feel extremely high and full of energy
- ☐ Feel anxious – you may feel this as aches, chest pain, shortness of breath, numbness, tingling or "lump" in the throat
- ☐ Feel guilty and ashamed, thinking you are not a good mother
- ☐ Not be bonding with the baby, or be afraid to be alone with the baby
- ☐ Have repeated scary thoughts about the baby

**Don't wait. There is help for you and your family.**

- Your healthcare provider (family physician, midwife, nurse, OB/GYN)
- INFO line to find your public health agency: 1 866 532 3161
- Telehealth Ontario: 1 866 797 0000 or TTY 1 866 797 0007
- Mental Health Services Information Ontario: 1 866 531 2600
- Our Sisters' Place: www.oursistersplace.ca
- The Best Start Resource Centre's Postpartum Mood Disorder Campaign: www.lifewithnewbaby.ca

**Very rarely women will have postpartum psychosis.**
This is a serious illness with risks to mother and baby.
**Have you felt like this even for a short time? You may:**

- ☐ Have thoughts of harming yourself or the baby
- ☐ Hear or see things that are not there
- ☐ Believe people or things are going to harm you or your baby
- ☐ Feel confused or out of touch with reality

**Don't wait. Get help right away.**

- **Go to:** Your local hospital's emergency department
- **Or call:** Your local crisis intervention line

### WHAT YOU CAN DO:

- **Ask for help**
- **Take care of yourself**
- **Take time for yourself**
- **Get counseling or join a support group**
- **Consider medication**

### WHAT A PARTNER, FAMILY AND FRIENDS CAN DO:

- **Listen and support her feelings**
- **Encourage her to seek professional help**
- **Develop your relationship with the baby**
- **Ask her how you can help**
- **Educate yourself about postpartum mood disorders**
- **Take some time for yourself**
- **Find someone to talk to**

**Remember... this is not your fault. There is help for you and your family**

best start
meilleur départ
Ontario's maternal, newborn and early child development resource centre
Centre de ressources sur la maternité, les nouveau-nés et le développement des jeunes enfants de l'Ontario

Ontario Prevention Clearinghouse
Centre ontarien d'information en prévention

2006

Short version!

# STAGES *OF TREATMENT:*

## *crisis management - "put out the fire" stage*

### *1) Denial: - Goal: stabilization and symptom relief*

Objective: **VALIDATION:**

**In order to establish "therapeutic alliance" it is critical to maintain an attitude of non-judgmental acceptance of all negative feelings-guilt, shame, and especially anger. Do not minimize the level of distress, discount the painful feelings, or offer re-assurances of a quick fix.**

**In order to assist the client remove judgement from her feelings and to reduce self-blame, initial emphasis should be placed on the biological contributing (risk) factors. Ppd is a developmental biological crisis which "may" be exacerbated by environmental stress.**

**Be sensitive to the shame and stigma of negative feelings at a time when she "should" be at her most happiest time of life.**

**Listen to the story and how she makes sense of her experience. Gently inquire about worries and fears but don't offer any coping strategies at this time-only reassurances that "normalize" her feelings.**

**Ask her what she thinks would be helpful in order to bring her stress down even one notch. Tentatively propose an easy strategy that helps her deal with her most distressing symptom- "Worst first ." Reassure her that if this doesn't work, that's okay.**

**Review Beck's list of ppd symptoms-validation and assurance.**

**Reassure her that there will not be any negative impact on the infant because she is getting help. Important to convey that "going through the motions" is okay for now.**

Objective: **EDUCATION: countering "what does the problem need for survival."**

**What does ppd look like? Risk factors?**

**Where on the spectrum am I? Stages of healing and the"ups and downs"**

**Why Me? What makes me vulnerable?**

**Consequences of ppd on: self-esteem**
**perspective**
**cognitions**
**physically**

**Consequences of ppd on relationships-especially partners. (Don't focus on neg. effects of ppd on infants and children.)**

**Education around pharmaceutical interventions and an explanation as to how they work-emphasize that BDZ are okay short-term and that AD are not-addictive. Permission may be required-emphasize that early intervention will shorten the time of distress and do a "cost-benefit" analysis of meds and breast-feeding.**

**May need to advocate on behalf of client with family physician or similar-be prepared to do so!**

**Remind self and the client that although ppd falls under the DSM as post-partum onset, it is "qualitatively" different than other reactive depressions. A new person to care for and the added burden of**

**"no permission" exacerbates the symptoms.**

**Always identify any personal biases and strive for transparency and authenticity with your client.**

***beyond crisis - "formulation of a new blueprint" stage.***

**2) <u>Acceptance</u>/integration of "label"**
**Goal: teaching of survival skills**

Objectives: **EMPOWERING:**

**Must assess and develop a support network.**

**Implementation of boundaries and recognition of pos./neg. "supports." It is not unusual for the new mom to insist that she can't be alone-creative support strategies that partner can implement and feel good about.**

**Safe expression of strong feelings-how to protect self and others from toxic "overflow."**

**Assess and develop self-care skills as required. Nurturing of self is critical. Discuss the "spiral of healing" and survival strategies required to cope with what feels like a setback.**

**Exploration of societal myths and personal expectations that contribute to stress. Avoid labeling: "high functioning" is preferable to "perfectionist personality" or other pejorative self-labeling. Only fuels the self-blame. This is not the time to try to change who we are! Better to examine how some of the coping strategies that normally work, may be backfiring on us now.**

**Exploration of "grief and loss" issues that result from "unmet" expectations.**

**Teaching "tools for survival" simple skills that facilitate management of : anxiety which is often the most intrusive symptom of ppd. Strategies for dealing with scary and intrusive thoughts, obsessive thoughts and "worries" may be gently introduced. Must assess for readiness in this regard; if the client is unable to implement these simple strategies, she may blame self. The intent is to lessen the distress and not to add to the "workload."**

**Recognition and management of stressors that may exacerbate the symptoms - get supports involved here.**

**Management of feelings through journaling, recognition of triggers that set off negative self-talk or anger. Thought stopping strategies and other cognitive interventions that may be helpful-again, offer tentatively and follow up with feedback. It is critical to maintain "hopefulness" so if something doesn't work, than focus elsewhere for a "locus of control."**

**Exploration of FOO issues only in how they may influence "dysfunctional" coping mechanisms at this point.**

**Exploration of relationship with partner issues and ways to facilitate better communication and avoid polarization. (Dads' nights are N.B.)**

**Child rearing issues and resolution of guilt.**

**Impact of ppd upon sexuality.**

**Role adjustment issues and expectations.**

**"De-construction" of old, unhelpful beliefs about**

**motherhood and expectations.**
Depression makes everything look "huge.

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***moving on - "re-wiring the house" stage.***

***3) <u>Reconciliation</u>: - Goal: getting beyond victim hood-hope and healing***

Objective: **RE-INTEGRATION OF SELF:**

**Recognition of "preferred ways of being" now that perspective is back.**

**Re-building relationships and letting go of disappointments with self and others-forgiveness.**

**Re-connecting with lost hopes and ideals and grieving unmet expectations.**

**Integration of the concept of "crisis as a time of growth." Discovering new skills and a new capacity for empathy and understanding.**

**Integration of coping skills and strategies which can be employed beyond the depression.**

**Recognition of triggers and better ways of communication with others. Acknowledgment of increased capacity for survival.**

**Coming to terms with the loss of innocence.**

**Re-construction of new beliefs that support and sustain growth beyond the pp-a time of learning more about the self.**

**Final stage of recovery - "re-authoring" and sharing the story with an audience - discovering who is on your team"!**