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Rosanne Nunnery
Capella University

Missy Fauser
Capella University

Elizabeth Hatchuel
Capella University

Mary Jones
Capella University

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*The Use of Dialectical Behavioral Therapy
(DBT) Techniques Creatively in the
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Rosanne Nunnery
Missy Fauser
Elizabeth Hatchuel
Mary Jones
Capella University

Abstract

Perinatal Mood and Anxiety Disorders (PMADs) is a serious condition impacting up to 21 percent of woman after the birth of a child (Byrnes, 2018). Jane, a 32-year-old female presented for treatment for anxiety, depression and mood disturbance (5th ed.; DSM-5; American Psychiatric Association, 2013) and in need of feeling more connected to her baby and her life. The use of creative techniques including mindfulness, distress tolerance activity, emotion regulation, and interpersonal skills (Linehan, 2015, 2016) were implemented. The use of these skills can be added to the repertoire of practice of a mental health counselor working with clients with PMADs.

Having a baby can be a beautiful experience but it can also come with significant emotional distress. Many women are told that their postpartum struggles are either a normal part of the adjustment to motherhood or “the baby blues.” However, it is estimated that 15% to 21% of pregnant and postpartum women meet the diagnostic criteria for a Perinatal Mood and Anxiety Disorders (PMADs) (Byrnes, 2018). PMADs reflect a range of postpartum conditions to include postpartum depression, postpartum anxiety, postpartum obsessive-compulsive disorder, post-traumatic stress disorder (PTSD), and postpartum psychosis (Byrnes, 2018). Research has shown that PMADs impact women of every culture, age, income level and race. While there is no clear cause, some of the risk factors that are highly correlated with PMADs include low socioeconomic status, single parents, geographic location/isolation, and maternal age (Milgrom & Gemmill, 2015).

As a construct, PMADs offer a different and more nuanced lens through which clinicians can understand the various types of postpartum distress. Historically, most of the research on postpartum challenges has focused on postpartum depression (Fairbrother, 2016). This parallels stories that one sees in the media and “pop culture” where much of the reporting of a mom in crisis refers, often inaccurately, to postpartum depression. There are significant diagnostic and treatment differences between postpartum depression, postpartum anxiety, postpartum psychosis, and birth-related PTSD.

PMADs can have a significant impact on maternal behavioral responses and lasting impacts on a child’s emotional, cognitive, and behavioral health outcomes (Choi & Sikkema, 2017). Symptoms range in severity and focus but can include significant disruption of daily functioning, maternal suicide and infanticide. Despite these risks and the growing percentage of

women experiencing distress in the postpartum period, many practicing clinicians remain unaware of the unique clinical presentation and treatment needs for this population (Fairbrother, 2016). PMADs are different from traditional mood and anxiety disorders in onset, intensity, treatment, and recovery. There is also a growing body of research that suggests mishandling by the mental health and medical community can exacerbate PMADs symptoms and further traumatize new moms (Ali, 2018).

There are many reasons why timely intervention with PMADs is critical. First and foremost, with PMAD clients there is an increased risk for maternal suicide and infanticide (Ghaedrahmati, 2017). Supporting clients in distress is made more complicated by the fact that many women do not seek treatment because of feelings of shame, fear, and stigma related to perceived maternal failure. Researchers have also found that when practitioners are not trained in the nuances of treating PMADs, their efforts to “help” can cause more harm than good (Ali, 2018). As such, there is a growing call for clinicians to have more focused training and awareness surrounding the treatment of PMADs.

Assessment, Diagnosis, and Treatment of PMADs

Assessment

Clinical assessments are an essential component to effective treatment planning. There are three common assessments that can be used to measure and track PMADs. The Edinburgh Postnatal Depression Scale (EPDS) is a 10 item self-rating instrument that measures the cognitive and emotional symptoms of postpartum depression (Cox & Holden, 2003; Sumitra et al., 2016). The

Perinatal Scary Thoughts Action Algorithm (PPSC) Suicide Assessment provides 17 follow-up questions to the EPDS to provide additional screening for suicidal ideation and intent when a client has a positive EPDS screen (Kleiman, 2015). Another common self-rating instrument, the Postpartum Distress Measure (PDM), is composed of 10 ratings that can be used to screen for postpartum distress symptoms of depression and anxiety (Allison et al., 2011).

Diagnostic considerations

When a client presents for treatment, counselors are encouraged to work collaboratively with the client to determine presenting problems, identify goals for treatment, and make a plan for effective treatment intervention (Sommers-Flanagan & Sommers-Flanagan, 2017). Women presenting with a range of symptoms in the postpartum period should be screened carefully to ensure accurate diagnosis. As previously noted, the term “PMADs” captures a range of presenting issues to include Postpartum Depression, Postpartum Anxiety, Postpartum OCD, and Postpartum Psychosis. The term “postpartum depression” is often used as a catch-all for a variety of PMAD symptoms ranging from the Baby Blues to Postpartum Psychosis. For the purpose of this paper, Postpartum Depression and Postpartum Anxiety will be highlighted specifically as they are the most diagnosed types of PMADs (Kendig et al., 2017).

Postpartum depression signs and symptoms are often seen as the typical symptoms of depression including: frequent crying, changes in sleep patterns, appetite changes, feeling sad and or hopeless, not enjoying activities usually enjoyed, and confused thinking and/or trouble making decisions (5th ed.; DSM-5; American

Psychiatric Association, 2013). Postpartum depression can also result in stronger emotions such as anger and rage, fear that one is not a good mother, hopelessness, shame, guilt or inadequacy. Recurring thoughts of suicide or death can occur. Postpartum depression can severely impact relationships such as withdrawing from loved ones, difficulty bonding with the baby or having thoughts of harming oneself or the baby. The physical symptoms may include fatigue, restlessness and loss of energy (5th ed.; DSM-5; American Psychiatric Association, 2013).

In assessing for PMADs, it is important to consider a variety of diagnostic rule outs. For example, symptoms such as emotional lability, depressed mood, and anxiety could be indicative of a variety of Mood and Anxiety Disorders. The timing of symptom onset will often help to make this distinction more evident. Other diagnostic considerations include: Major Depressive Disorder with Peripartum Onset, Bipolar Disorder with Peripartum Onset, Postpartum Mood Disturbance, Brief Psychotic Disorder with Peripartum Onset, Adjustment Disorders, Generalized Anxiety Disorder, Obsessive Compulsive Disorder, and Posttraumatic Stress Disorder.

Evidence-Based Treatment of PPD

Evidence-based treatment of PMADs is relatively new in the research. Karen Kleiman, one of the clinicians who has pioneered the treatment of women with PMADs, suggests the use of Winnicott's theory of "therapeutic holding" as a foundation for PMADs work; this refers to a therapist's capacity to respond to postpartum distress in a way that facilitates an immediate and successful therapeutic alliance (Kleiman, 2017). There are a variety of clinical approaches that have

shown to be successful in the treatment of PMADs to include cognitive behavioral therapy, narrative therapy, mindfulness-based stress reduction and feminist theory (Milgrom & Gemmill, 2015). Given the relative "newness" of PMADs and the limited research on evidence-based practices, Byrnes (2017, p. 512) notes that developing and testing culturally sensitive interventions for PMADs should be made a priority for women.

It is widely accepted that Dialectical Behavior Therapy (DBT) is an effective therapeutic approach to use in the treatment of depression, anxiety, and PTSD (Forman et al., 2007; Harley et al., 2008; Fassbinder et al., 2016). However, new research is starting to explore the use of DBT in the treatment of perinatal and postpartum depression. Kleiber et al. (2017) conducted one of the first studies to examine the use of DBT skill training in a group of adolescent women with perinatal depression. Group sessions focused on skill training across four DBT modules; Mindfulness, Emotion Regulation, Distress Tolerance, and Interpersonal Effectiveness. Their findings provide support for using DBT as a treatment strategy "credible and acceptable" with many participants reporting a reduction in depressive symptoms. Kleiber et al. (2017) also highlighted the need for further development of these types of treatment programs and noted iterations of the treatment may be administered individually.

A more recent study by Huang et al (2020) explored the use of DBT skills training for a patient who was diagnosed with COVID-19 in China and hospitalized during the late stage of pregnancy through early postpartum. In an effort to manage emotional distress and avoid the use of psychotropic medication, researchers utilized a variety of DBT techniques with

the patient to include mindfulness and relaxation exercises, distress tolerance skills, and interpersonal relationship skills. Results indicate that DBT is an appropriate and helpful intervention to utilize as the patient reported a reduction in symptoms related to depression and anxiety. The authors also highlighted that more research is needed on the role DBT can play in crisis intervention and supporting clients with trauma (Huang et al, 2020). To understand PMAD better and its link to DBT creative techniques, a case example will be utilized to show the steps of the problems, goals, and implementation.

DBT and PMAD

Understanding the primary foundation of DBT and applying it to the case of women diagnosed with PMADs requires a creative lens for clinicians. The DBT approach offers a framework that balances acceptance, change and skills by examining dialectical thinking, communication patterning and a desire for all humans to be accepted. A core tenant of DBT involves validation so it behooves clinicians to have a thorough understanding of how important validation is within the therapeutic alliance. Linehan (1993,1995) indicated that an invalidating environment can result in dysregulation, difficulty with managing emotional responses, and cause a shut down and difficulty communicating needs and wants in an assertive manner. The relationship between counselor and client begins with the primary validation of the individual's present experience and existence. It is critical that the counselor accepts the client and communicates this by taking the client's responses seriously without discounting or trivializing them (Linehan, 1993, 1995, 2015, 2016). This involves hearing the experience of the client and evoking a level of understanding of the

emotions in light of the history and overall context of the situation. This validating environment sets the tone to begin working with women with PMADs and is a catalyst to begin the process of integrating specific problem-solving strategies and the skills that guide change.

DBT is a complex treatment process that includes specific protocolized treatment and long-term commitment for individuals typically diagnosed with borderline personality disorder. One element of the DBT model is the implementation of DBT skills modules that include teaching mindfulness, interpersonal effectiveness, distress tolerance and emotional regulation (Linehan, 1993, 1995, 2015, 2016). When working with individuals diagnosed with PMADs, these DBT modules can be utilized in whole or in part based upon the treatment needs of clients. To effectively implement them into treatment, counselors should have a general knowledge of DBT skill areas when creating a treatment plan. These skill areas and Linehan's (2015, 2016) training modules provide step by step guidelines for implementation.

Linehan studied Zen Buddhism and incorporated its mindfulness concepts into DBT Skills training (Linehan, 1993, 2015, 2016). Mindfulness has been defined in many ways but it is considered to be a purposeful focus and does not have to be meditative. Mindfulness discourages attachment to the moment along with accepting the moment without judgement. This helps the client to notice where they are in the moment combined with an examination of where they want to go. This is possible by practicing "what and how skills" developed by Linehan (1993, 2015, 2016). Mindfulness skills are designed to reduce suffering, pain, tension and stress and encourage a focus on the present so that

one's mind does not control the person. While reducing areas of distress, there is an increase in happiness, a sense of control of the mind, a sense of seeing reality as is and accepting it along with facing the world with open eyes of awareness (Linehan, 2015, 2016). Linehan's skills manuals provide a plethora of handouts designed to assist with clients with practicing mindfulness. For the purpose of working with individual's diagnosed with PMADs, the application of the skill of "wise mind", "observe, describe and participate", and "loving kindness" meditation (Duncan & Bardacke, 2010; Linehan, 1993, 2015, 2016) are applicable to the case scenario.

DBT theory posits that humans have the capacity to tolerate crisis and stress and that individuals can learn to endure pain and make meaning out of distress events with the practice of distress tolerance skills (Linehan, 1993, 2015, 2016). The goal of distress tolerance skills is to enable individuals to survive crisis situations (or perceived crisis situations) without exacerbating the crisis, learn what cannot be changed, and free oneself from allowing events to control emotions and behaviors (Linehan, 2016). This includes accepting the reality that suffering happens to everyone yet some find a way to move forward. Linehan (2015, 2016) believed that pain and unacceptance can lead to ongoing suffering. When clients understand the normality of pain with acceptance, it can help make it manageable (Linehan, 2015, 2016). It is important that PMADs clients are aware that they do not have to live in a state of crisis. Part of knowing when to implement distress tolerance skills includes understanding what is considered a crisis and knowing when to use a set of specific skills when the need arises. Handouts specific to distress tolerance might include the use of distracting, self-soothing, improving the

moment and considering pros and cons when there is an overwhelming sense of crisis and doom (Linehan, 1993, 2015, 2016, Russel & Lincoln, 2015).

Emotions are a part of every human although DBT notes that some individuals will have more intense emotions than others. Thus, the overall goal in emotional regulation is not to eliminate emotions but rather to eliminate suffering. Emotional regulation skills in DBT fall under the focus of change skills and are linked to factors such as the emotion mind (Linehan, 1993, 2015, 2016). The training is geared toward identifying and labeling affect, examining obstacles to changing emotions, seeking reduction of the influence of the emotion mind, increasing positive emotional responses to events and increase purposeful and mindful awareness to current emotions (Linehan, 1993, 2015, 2016). Emotion regulation involves learning how to manage and impact the emotions that an individual has along with how these emotions are both expressed and experienced daily (Goss, 2014). Using DBT it is important to teach clients to identify emotions, the normalcy of emotions in relation to recent circumstances and apply skills to reduce the distress. DBT has an overall goal of assisting a client to be able to experiencing a life worth living. There are times that women will need to consider personal goals of maintaining self-care and cultivating positive emotion moments (Linehan, 1993; 2015, 2016; Haga et al., 2012).

The ability to engage with people on a personal level is critical to effective relationships with others. Part of this includes the ability to connect with others while maintaining appropriate boundaries. There is a need for a healthy balance between alienating others and compromising while effectively meeting personal goals

with healthy boundaries (Linehan, 2015, 2016). DBT's interpersonal effectiveness skill modules are designed to assist clients with being skillful in three primary areas. The first is a need to know how to achieve personal objectives including effectively communicating requests and needs and saying no to unwanted requests. Another interpersonal effectiveness module involves the importance of building relationships and learning how to end destructive relationships (Linehan, 1993, 2015, 2016). A final primary area of interpersonal effectiveness is learning to walk the middle path. This includes learning how to consider validation of others points of view to promote acceptance and change (Linehan, 1993, 2015, 2016; Rathus et al., 2015). These skill areas are beneficial with clarifying relationship goals, personal priorities regarding relationships and learning how to engage in situations where familiar and unfamiliar individuals are engaged in a group context. These skill areas are important because clients with PMADs can exhibit overwhelming depression that impacts personal engagement with family, friends, and specifically an intimate partner (Garthus-Niegel et al., 2018).

The ability to engage with people on a personal level is critical to effective relationships with others. Part of interpersonally relating to others includes the ability to connect with others while maintaining appropriate boundaries. There is a need for a healthy balance between alienating others, compromising and effectively meeting personal goals with healthy boundaries (Linehan, 2015, 2016). These skill areas are beneficial with clarifying relationship goals, personal priorities regarding relationships, and learning how to engage in situations where familiar and unfamiliar individuals are engaged in a group context.

Case Study

To illustrate how DBT might be used in the treatment of PMADs, a hypothetical client, "Jane," will be presented. Jane represents a composite of typical postpartum clients who are presenting with a range of PMAD symptoms with emphasis on anxious and depressive symptoms.

Presenting Symptoms

Jane is a 32-year-old Caucasian female who was referred for treatment by her obstetrician and gynecologist for "feelings of depression, anxiety, and mood disturbance" following the birth of her first child. She is currently 7 weeks postpartum and arrives for her first appointment with her baby. Jane is oriented to name, location and time, well-dressed, and well-spoken as she discusses what brings her to treatment. Jane is set to return to work in 5 weeks and is experiencing feelings she has "never had before." She reports crying frequently during the day, has difficulty sleeping, and increased frustration with her partner. When asked to elaborate, she described being annoyed by "just about everything" and that nothing seems to make her feel better. While she doesn't feel disconnected from her baby, she does report fantasizing about what her life was like before she became a mother and longing to have a "carefree life" once again.

Jane denied any suicidal or homicidal thoughts when asked by her physician. But she did say that she is tired of dealing with this every day and has little hope that things are going to get better. She feels alone in parenthood and is wondering if she made a mistake in becoming a parent. She described her current coping skills as extremely limited. She is resistant to taking medication for symptom management as she

is breastfeeding and “wants to learn how to solve this herself.” She reports that she wants to “feel like herself again.”

Client History

Jane reports no previous history of significant depression or anxiety. She has always had high expectations for herself and feels like she has been successful in most areas of her life. She was thrilled to start her family with her husband and described an “easy pregnancy and delivery”. She noticed she was not feeling herself shortly after the baby was born but wrote it off as “the baby blues” everyone talks about. She does not have family in the area but her mother did come to visit for the week after the baby was born. Her mother told her “having a baby is hard” and that she would be fine in a few weeks. She indicated she did not feel like she could tell her mom how hard it was for out of fear of disappointing her. She says it is hard to ask for help from those around her as people are accustomed to her being on top of things. Aside from her husband, no one knows she is struggling. When asked about spiritual supports, Jane said “she has not felt connected to God for some time” and does not feel like she would find much help at her church.

Assessment & Diagnosis

At the beginning of the intake session, Jane completed The Edinburgh Postnatal Depression Scale (EDPS) with a total score of 16 (out of 30). A score of 10 or higher suggests that minor or major depression may be present further evaluation is warranted (Schaper et.al, 1994). In addition to looking at the total score for the EDPS, it is critical the clinicians review Item 10 as it focuses specifically on suicide risk. On item 10 (i.e., “The thought of

harming myself has occurred to me”) Jane endorsed “Hardly Ever.”

Based on the results of the EDPS and her intake interview, Jane meets the diagnostic criteria for Postpartum Depression (F53.0). Postpartum depression signs and symptoms are often seen as the typical symptoms of depression including: frequent crying, disruption in sleep patterns, appetite changes, feeling sad and or hopeless, not enjoying activities usually enjoyed, and confused thinking and/or trouble making decisions (5th ed.; DSM-5; American Psychiatric Association,). Jane agrees that she has been feeling very depressed but acknowledges that anxiety is also present.

Treatment progression and outcomes

The counselor-client relationship is a critical piece for a client like Jane to feel safe and to trust the counselor. Trust creates a space for disclosure of the personal concerns associated with being a new mother and all of the varied concerns that arise for mothers. Having this foundation provides a framework when DSM-5 diagnostic considerations (5th ed.; DSM-5; American Psychiatric Association,2013) are considered for treatment outcomes.

Art-Based Therapy, DBT, and PMAD’s

Creativity in the form of art-based activities can play an important role in the treatment of PMADs. Sarid et al. (2017) posit that it is important to find non-stigmatizing, strength-based interventions when providing treatment to women who are experiencing perinatal mood and anxiety disorders. They state, “Art therapy generates a symbolic, therapeutic narrative, engaging the senses through observing, touching, and manipulating art materials,

creating a connection between mind, body, and cognition” (Said et al., 2017, p. 229). This process, in turn, helps women increase coping skills and self-esteem, and decrease overall stress.

There is a small body of literature that supports the claim that art therapy and art-based interventions can support mothers who are experiencing PMADs. Positive outcomes reported include an increase in self-assurance, sense of wellbeing, self-image, and self-esteem (Hogan et al., 2017; Morton & Forsey, 2013; Ponteri, 2001). Research has also found that art making helps new mothers relieve stress (Perry et al., 2008; White et al., 2010) and has a positive effect on mood (Morton & Forsey, 2013).

Perry et al., (2008) report that creative arts can be complementary to conventional therapies when treating PMADs, especially in cases that are not severe. Utilizing art-based interventions to support core DBT principals is an example of this (Clark, 2016; Heckwolf et al., 2014; Franklin, 2010; Kalmanowitz & Ho, 2017; Monti, et al., 2006). Case studies combining DBT and art therapy document the successful outcomes that can occur when combining the two approaches (Huckvale & Learmonth, 2009; Heckwolf et al., 2014).

Clark (2016) has discussed in detail the success of bringing DBT and art therapy together. The author suggests that art activities combined with DBT help to “facilitate mindfulness, the foundational DBT skill, by engaging clients in a novel, process-oriented experience” (Clark, 2016, p. 11). Daler and Schwanbeck (2014) have developed a model called “Creative Mindfulness” which combines expressive arts therapy with DBT. They report that goal of the model is to integrate the

effectiveness of DBT with the creative and sensory modes of self-expression and learning of expressive arts therapy (Daler & Schwanbeck, 2014). While integrating DBT with expressive arts, Daler and Schwanbeck (2014), much like Clark (2016), found that utilizing creative techniques helped to engage their clients and promote an openness around exploring new concepts. The following hypothetical case application provides examples of creative interventions, each combined with a DBT tenet, and how they are utilized in the case study of Jane.

Creative DBT Case Application

Mindfulness Activity: Here and Now Meditation and Mandala

Objective: This mindfulness activity will allow Jane to become more grounded, experience living in the “here and now”, and help to reduce pain, tension, and stress.

Materials: 8x10 paper, circular objects/stencils for tracing, various drawing tools such as markers, colored pencils, gel pens, and oil pastels. Watercolor and acrylic ink may also be included if the therapist has knowledge of the medium.

Procedure: The therapist led a brief guided meditation that allowed Jane to quiet her mind and experience the present moment. Jane then utilized art materials to draw on the inside of the circle, using shapes and colors that represented her experience in the “here and now”.

Processing: Upon completion of the artwork, Jane was encouraged to process the experience and her artwork verbally with the therapist. Questions for Jane to ponder included: Did you notice any shifts in your emotional experience throughout the process? Was it easy to stay in the present or

did your mind tend to wander throughout the exercise? What senses were you aware of as you created your art? Do any symbols or colors seem to stand-out to you in your artwork?

Outcome: Jane was able to reflect on the emotional shifts that occurred during the meditation and art creation. She reported a decrease in anxious feelings and a decrease in the tension in her body. Jane pointed out colors and shapes that represented calmness and relaxation. She reported that she would hang the mandala drawing on her refrigerator as a visual reminder for her to practice mindfulness skills throughout her day.

Distress Tolerance Activity: Self-Care Kit

Objective: This distress tolerance self-care kit contained useful activities to encourage Jane to practice the coping skills of self-soothing, distraction, and acceptance.

Art Materials: Canvas bag with fabric markers, fabric paint, stamps, screen printing supplies, etc. (a box with a lid and a variety of collage, painting, and drawing materials could also be used for this exercise). Examples of items to put in the kit: Crossword puzzles, favorite magazines, basic art supplies, sketchbook/journal, affirmation cards, joke cards/book, favorite book, worry stone, stress ball, putty, coloring pages, gum/candy, favorite essential oil, small photo album, worry beads, CD/MP3 Playlist, teabags, and spiritual literature.

Procedure: Jane used the art materials provided to decorate the canvas bag that would hold the items for her self-care kit. Jane worked together with the therapist to brainstorm materials that would go into the self-care kit.

Processing: Jane shared some of the special items she will be putting in her self-care kit, including essential oil rollers, a stress ball, and mint candies to engage her senses for grounding. She also included a small blank journal and colored pencils for creative journaling, affirmation cards for motivation and self-reflection, and her favorite book to aid in distraction. Jane and the therapist also discussed examples of times when the items in her self-care kit might be especially helpful.

Outcomes: A few weeks after creating the self-care kit, Jane shared that during times she was feeling especially anxious when her baby was fussy, she was able to utilize the essential oil rollers and mint candies, along with relaxed breathing to help her stay calm and grounded. She also reported that when she found herself awake at night, unable to sleep due to her anxiety and depression, she was able to engage in creative journaling to help calm herself, which in turn made it possible for her to go back to bed and fall sleep. Jane reported that successfully utilizing the distress tolerance skills also increased her confidence in her ability to be resilient and manage her emotions.

Emotional Regulation Activity: A Life Worth Living Vision Board

Objective: This emotional regulation activity helped Jane to identify and affirm her values and goals to focus on creating “a life worth living”. The activity also helped Jane to identify obstacles to changing emotions and ways to increase positive emotional events.

Materials: Large paper/poster board, scissors, magazines/collage material, glue sticks, gloss medium, various drawing tools such as markers, colored pencils, and gel pens.

Procedure: Jane utilized the art materials provided to create a vision board around the general theme of “a life worth living”. The vision board included images, words, and phrases cut from magazines and motivational quotes that are important to Jane.

Processing: Upon completion of the vision board, Jane processed her artwork verbally with the therapist and later through written word in her journal. Topics discussed included Jane’s vision of cultivating “a life worth living”, possible action steps towards meeting her goals and positive intentions and affirmations that will help Jane to increase her motivation while moving forward.

Outcome: Jane was able to process obstacles to “a life worth living” and identify which short- and long-term goals she would be able to accomplish to help her manage her expectations. This allowed her to connect her goals with cultivating future positive emotional events. Jane was able to journal about the thoughts and emotions that she experienced when looking at the board for several weeks after she created it. In subsequent sessions, she reported an increase in awareness around the unrealistic expectations she tends to set for herself as a mother and wife. She also shared some of the steps that she had made towards meeting her short-term goals. These included signing up for a weekly yoga class and reaching out to a friend for help in reorganizing certain areas of her home so that she could be more efficient in her day-to-day living, thus decreasing her overall stress.

Interpersonal Effectiveness Activity: Boundary Drawing

Objective: This interpersonal effectiveness activity allowed Jane to explore the importance of healthy boundaries and reflect on how she could implement them in her life.

Materials: 8x10 paper, various drawing tools such as markers, colored pencils, gel pens, and oil pastels.

Procedure: Jane and the therapist discussed the various types of boundaries that are present in relationships (rigid, weak, healthy, etc.). Jane then explored her current boundaries by creating a piece of artwork using the metaphor of a castle/fortress.

Processing: Upon completion of the artwork, Jane was encouraged to process the experience and her artwork verbally with the therapist. Questions for processing included: Who do you let inside your fence/wall? Who do you keep out? What factors do you consider when deciding who to let in and keep out? What actions might you take to create boundaries as you would like them to be? Processing this turned into a wider discussion on needed communications skills such as assertiveness and active listening. A second image was also be created later in the week in her creative journal to allow Jane to explore how she would like her boundaries to be in comparison to the boundaries reflected in her first drawing.

Outcome: Jane was able to increase awareness around boundaries in particular

relationships in her life, specifically focusing on the times when she failed to use her boundaries and assertiveness skills to say no to others who ask her for help or favors when she is feeling overwhelmed. She also discussed the times when she tends to “shut people out” when she becomes overwhelmed and resentful. Through the use of role play in later sessions, Jane was able to practice assertiveness skills so that she would be able to feel more comfortable saying no to requests for favors when she is overwhelmed, stressed, and tired. Jane made progress with creating healthy boundaries during her time in therapy, although she admitted that she sometimes “slipped and would say yes” when she really didn’t want to. This led to processing around self-compassion and forgiveness, as well as more practicing of skills via role play.

Overall Treatment Outcomes Compared to the Literature

Jane’s experience of decreased anxiety and decreased physical tension during and after mindfulness-based practices and art-based activities correlate with the literature on the topic (Kalmanowitz & Ho, 2017; Park, Lee, & Lee, 2016; Perry et al., 2008; Sarid et al., 2017; White et al., 2010). Her successful use of distress tolerance skills, aided by the self-care kit, and her increased confidence reflect similar outcomes discussed by several authors (Hogan et al., 2017; Morton & Forsey, 2013; Ponteri, 2001; Sarid et al., 2017). Jane’s development of self-awareness and self-assurance over time, her willingness to explore new ideas, and her ability to take action steps towards cultivating positive emotional events and increased interpersonal effectiveness are similar to many outcomes described in the literature on the topic (Daler

& Schwanbeck, 2014; Hogan et al., 2017; Morton & Forsey, 2013; Ponteri, 2001).

Treatment goals and modalities: Initial goals focus on symptom reduction (e.g., decreased mood, sleep disruption, irritability), education on perinatal mood and anxiety disorders, development of coping skills and a potential referral for medication evaluation. Another goal is to provide DBT skill training with mindfulness, emotion regulation, distress tolerance and interpersonal effectiveness modules. As these are established and implemented with a client, counselors must keep in mind factors that are associated with postpartum depression and how derailment can happen.

Complicating Factors

There are many factors to consider when treating PMADs such as medical complications and barriers to care. Risk factors may include depression and/or anxiety during, prior or after pregnancy, low social supports, difficulties breastfeeding, admission of infant to a neonatal intensive care unit, preterm birth and stressful life events during or after the birth (Rai et al., 2015).

Returning to work can provide obstacles including lack of financial or social support. One in four women return to work within 10 days of delivery. Only 14% have access to paid leave. While the 1993 Family Medical Leave Act provides 12 weeks of unpaid leave, it only covers 60% of the population (American College of Obstetrics & Gynecologists, 2018). Barriers to care exist for women who are immigrants or non-citizens, endure physical and mental disabilities, are homeless or have non-English speaking status. Other patients have concerns that perinatal care providers lack

education about postpartum depression and will be judgmental in their approach (Moore et al., 2018).

Medical factors that emerge during pregnancy and after need evaluation. Complications such as preterm delivery, gestational hypertension and/or diabetes, urinary incontinence and preeclampsia need monitoring. Postpartum thyroid disease can occur in women with no history of it prior to delivery. Many women are challenged by a lack of sleep, breastfeeding challenges, pain, fatigue and lack of sexual desire (Byatt et al., 2012).

Conclusion

Dialectical Behavior Therapy is an evidenced based approach designed to treat individuals with emotional dysregulation. Although women with PPMDs do not have a genetic link to emotional dysregulation, the realities of pregnancy, labor and delivery can bring on a variety of signs and symptoms creating a need for clinical treatment. Various assessments can be utilized to successfully assess for proper diagnosis and treatment planning. As treatment goals are established, the use of creative techniques aligned with DBT can assist with improving PPMDs symptoms in helping a client, such as Jane, improve.

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