Welcome to the Crouse Perinatal Family Support Program

We are so happy that you have taken this step to reach out for support. We understand that being a mom can be challenging and overwhelming at times. Our caring team of professionals, most who have experienced postpartum anxiety and depression firsthand, are here to support you on your journey to wellness. You will get better with help and we are here for you!

Below you will find some important information and resources:

Office hours 9 a.m. – 4 p.m.

Appointment scheduling or changes: 315-470-7747

Medication refills: 315-470-7747

New patient referral line: 315-470-7940 (calls retuned within 2-3 business days)

Billing questions: 315-937-3019

Crouse Family Peer Support Group: crouse.org/familysupport to access zoom link for groups Tuesday 6 p.m. and Friday at noon

Additional Resources

Postpartum Resource Center of NY – www.postpartumny.org

Postpartum Support International – www.postpartum.net

If you feel you may hurt yourself or someone else please call 911 or 211.

DO NOT CONTACT the provider via cell phone for an emergency as we are not on call 24/7.

Please check with your insurance provider regarding coverage for mental health services. We participate in most insurances and will work with you to help get you the support you need. If you have financial issues and cannot pay, please visit crousemed.com for information.

We welcome you to our community of support and are here for you!

Christine Kowaleski, DNP: Program Administrator
Kathleen Miller Murphy, RNC, CCE: Director of Women's Health Integration
Karen Bennett RN, MSN and Victorian Earle, LPN: Support Group Facilitators
Jessica Liepke, Program Coordinator

Perinatal Mental Health Discussion Tool

As many as 1 in 7 moms (1 in 10 dads) experience symptoms of depression and anxiety during the postpartum period. People of every age, income level, race and culture can develop Perinatal Mood and Anxiety Disorders (PMADs) during pregnancy and within the first year after delivery. This tool can help track your symptoms and discuss them with your medical provider. Being your own advocate is okay and you deserve to be well.

I have been experiencing the following symptoms: (please mark all that apply)

- Feeling depressed or void of feeling
- Feelings of hopelessness
- Lack of interest in the baby
- Trouble concentrating
- Brain feels foggy
- Feeling anxious or panicky
- Feeling angry or irritable
- Dizziness or heart palpitations
- Not able to sleep when baby sleeps
- Extreme worries or fears (including the health and safety of the baby)
- Flashbacks regarding the pregnancy or delivery
- Avoiding things related to the delivery
- Scary and unwanted thoughts
- Feeling an urge to repeat certain behaviors to reduce anxiety
- Needing very little sleep while still functioning
- Feeling more energetic than usual
- Seeing images or hearing sounds that others cannot see/hear
- Thoughts of harming yourself or the baby

Risk Factors

Below are several proven risk factors associated with postpartum depression (PPD) and postpartum anxiety (PPA). Knowing these risk factors ahead of time can help you communicate more effectively with your family and medical provider and put a strong self-care plan in place.

Please mark all risk factors that apply:

- History of depression or anxiety
- History of bipolar disorder
- History of psychosis
- History of diabetes or thyroid issues
- History of PMS
- History of sexual trauma or abuse
- Family history of mental illness
- Traumatic pregnancy or delivery
- Pregnancy or infant loss
- Birth of multiples
- Baby in the NICU
- Relationship issues
- Financial struggles
- Single mother
- Teen mother
- No or little social support
- Away from home country
- Challenges with breastfeeding

Resources

- **PSI Helpline:** For local resources please call 800-944-4773 or text us at 503-894-9453. We can provide information, encouragement, and names of resources near you.
- **FREE Online Weekly Support Groups:** Led by a trained facilitator. For days and times please visit: http://www.postpartum.net/ get-help/psi-online-support-meetings/
- **FREE Psychiatric Consult Line:** Your medical provider can call 800.944.4773 x 4 and speak with a reproductive psychiatrist to learn about medications that are safe for you to take while pregnant and breastfeeding. http://www.postpartum.net/professionals/perinatal-psychiatric-consult-line/

** This is not a diagnostic tool and should not take the place of an actual diagnosis by a licensed professional. **

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**…
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 ________

2. Did a parent or other adult in the household **often or very often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 ________

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 ________

4. Did you **often or very often** feel that…
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 ________

5. Did you **often or very often** feel that…
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 ________

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 ________

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, **often or very often** kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 ________

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 ________

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 ________

10. Did a household member go to prison?
    Yes No If yes enter 1 ________

Now add up your "Yes"answers: ________ This is your ACE Score

The Mood Disorder Questionnaire

Instructions: Please answer each question to the best of your ability.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
...you were so irritable that you shouted at people or started fights or arguments?		
...you felt much more self-confident than usual?		
...you got much less sleep than usual and found you didn't really miss it?		
...you were much more talkative or spoke much faster than usual?		
...thoughts raced through your head or you couldn't slow your mind down?		
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
...you had much more energy than usual?		
...you were much more active or did many more things than usual?		
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
...you were much more interested in sex than usual?		
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
...spending money got you or your family into trouble?		
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?		
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please select one response only.*		
No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?		
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?		

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Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: ______________________________ Address: ______________________________

Your Date of Birth: ______________________ ______________________________

Baby's Date of Birth: _____________________ Phone: ______________________________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☑ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week.
Please complete the other questions in the same way.

In the past 7 days:

1 I have been able to laugh and see the funny side of things
- As much as I always could
- Not quite so much now
- Definitely not so much now
- Not at all

2 I have looked forward with enjoyment to things
- As much as I ever did
- Rather less than I used to
- Definitely less than I used to
- Hardly at all

*3 I have blamed myself unnecessarily when things went wrong
- Yes, most of the time
- Yes, some of the time
- Not very often
- No, never

4 I have been anxious or worried for no good reason
- No, not at all
- Hardly ever
- Yes, sometimes
- Yes, very often

*5 I have felt scared or panicky for no very good reason
- Yes, quite a lot
- Yes, sometimes
- No, not much
- No, not at all

*6 Things have been getting on top of me
- Yes, most of the time I haven't been able to cope at all
- Yes, sometimes I haven't been coping as well as usual
- No, most of the time I have coped quite well
- No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
- Yes, most of the time
- Yes, sometimes
- Not very often
- No, not at all

*8 I have felt sad or miserable
- Yes, most of the time
- Yes, quite often
- Not very often
- No, not at all

*9 I have been so unhappy that I have been crying
- Yes, most of the time
- Yes, quite often
- Only occasionally
- No, never

*10 The thought of harming myself has occurred to me
- Yes, quite often
- Sometimes
- Hardly ever
- Never

[1] Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786.

[2] Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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ASQ Suicide Screening Questions Tool

(ASQ – Ask Suicide-Screening Questions)

	Yes	No
1. In the past few weeks, have you wished you were dead?		
2. In the past few weeks, have you felt that you or your family would be better off if you were dead?		
3. In the past week, have you been having thoughts about killing yourself?		
4. Have you ever tried to kill yourself?		

If yes, how?

When?

If you answer **Yes** *to any of the above, answer the following acuity question:*

5. Are you having thoughts of killing yourself right now?

If yes, please describe:

Resources

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text “HOME” to 741-741

CAGE Substance Abuse Screening Tool

	Yes	No
1. Have you ever felt you should cut down on your drinking?		
2. Have people annoyed you by criticizing your drinking?		
3. Have you ever felt bad or guilty about your drinking?		
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?		

CAGE is derived from the four questions of the tool: Cut down, Annoyed, Guilty, and Eye-opener

CAGE Source: Ewing 1984