

**Healthy Mothers, Healthy Babies:  
A Practicum Utilizing Self Regulation Therapy to Address Symptoms  
of Pre-Natal and Postpartum Depression and Anxiety.**

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## **Dedication**

I dedicate this paper to family: to my sons - Jorden and Adam, who provided the classroom in which I really learned about attachment, connection and healing; to my family, who model and epitomize resilience just by being; and finally, to my Mom – who did her best.

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## **Glossary of Terms**

H & H	Healthy and Home Program
HMHB	Healthy Mother, Healthy Baby Program
KF	KidsFirst
MHAS	Mental Health and Addiction Services
MMH	Maternal Mental Health Program
MSS	Ministry of Social Services
PPA	Pre-natal or post-partum anxiety
PPD	Pre-natal or post-partum depression
SE	Somatic Experiencing®
SRT	Self Regulation Therapy®

## Prologue

*A teen mom gives birth to her second baby. She had her first baby at 17. Both pregnancies were unplanned. This baby is colicky. Baby never seems to sleep and screams constantly. She tries, but nothing makes baby stop crying. She has no one to talk to.*

*She has a partner but he's young too. Neither was prepared for parenting. She didn't mean to stay with him, but then she got pregnant. Now she feels trapped. He drinks, and is sometimes abusive. He moves the young family to a small northern town. Isolated, she has no friends. He rarely lets her talk to her family and his family has disowned him. The baby cries. She cries.*

*The young mom gets sick. She has multiple sclerosis, and is hospitalized twice during her baby's first year of life. When she comes home from hospital she feels overwhelmed and helpless. She slides down into a profound depression.*

*The father stays away more and more often, and is angry and sometimes violent when he does come home. The mom self-medicates with tranquilizers and alcohol. She contemplates suicide and thinks of ways she could do it. The toddler tries to care for her baby sister and herself the best she can. Baby begins to cry less and sleep more. Sometimes she doesn't even wake up to eat. Mom feels guilty, but she's relieved.*

## **Introduction**

Tiffany Field (2003) begins her book *Touch* with the candid statement that “research is me-search”. Field asserts that we choose to study the areas we do because they are personally relevant. Consistent with this, in the therapy field there is often the underlying assumption that on some level we became therapists to deal with our own issues and/or exorcise our own demons. In regard to the previous vignette, these assertions may have merit, because the baby depicted was me and the young mom was my own. As an experienced therapist and self-analyst, I recognize that the circumstances I was born into and the care I received as an infant could well have had an impact on my development and personality.

Research does bear out and delineate the myriad ways that early relationships, especially those with our primary caregivers, can shape and potentially harm us (Wotherspoon and Gough, 2008; Siegel, 2008; Cozolino, 2006; Levine and Kline, 2007; Tarkan, 2004; Wotherspoon, Hawkins, and Gough, 2009; Levine and Kline, 2007; Streeck-Fischer and van der Kolk, 2000). The potential for damage to development, or attachment trauma, is especially relevant in the case of pre-natal or post-partum depression (PPD) or anxiety (PPA) . Even if all other health determinants are ideal, presence of PPD and PPA can create a toxic and potentially traumatic initial environment for infants (Field, 2003; Eisen, 2009; Shonkoff, 2009; Thompson, 2006; Albertsson-Karlsgren, Graff and Nettelbladt, 2001; Edhborg, Seimyr, Lundh, and Widstrom, 2000).

Research indicates that the first three years of a child’s life are critical in

terms of development (Levine and Kline, 2007). There is growing consensus that the nature and strength of our earliest attachments can directly shape and determine our future health and wellbeing (Siegel, 1999; Cozolino, 2006; Kennedy, 2001). When the primary caregiver suffers PPD or PPA, disruption to attachment can result, and development will likely be impacted or impaired. Cozolino (2006) states that “depression disrupts the ability of the mother-child pair to form optimal attunement, which, in turn, impacts the child’s ability to develop adequate internal emotional regulation” (p. 217). Tarkan (2004) indicates that there is evidence that even prior to birth, fetuses of mothers who are anxious or depressed respond differently than the fetuses of mothers who are calm. Tarkan states that, once born, these babies have a much higher rate of developmental and behavioural problems, and are more likely to succumb to depression or anxiety themselves.

The above suggests that if we had a parent with PPD or PPA, we likely experienced some degree of attachment trauma. As a result, as adults we may have a predisposition or vulnerability to depression or anxiety. While we may not have memories of any overt trauma or neglect, we also may not have an internal sense of what healthy attachment and attunement is. When we have children of our own, we may face uncertainty and fear about how to do it differently or more optimally. This can lead to feelings of helplessness and inadequacy, which can further contribute to anxiety and depression. Without intervention, the cycle can continue infinitely. PPD or PPA causes attachment trauma, which later manifests as anxiety and depression, which later still surfaces as PPD and PPA, which interferes with

attachment...and the toxic gift keeps giving - generationally.

Which begs the question of what can be done to break the cycle, rather than passing the ‘gift’ of attachment trauma or PPD/PPA on to our children. For decades therapy and counselling have focussed on the cognitive, primarily explicating feelings, thoughts and memories through ‘talk therapy’. Unfortunately, as indicated, if one’s infancy or childhood left scars, they may be internal, with no reflections or memories to analyze. Instead there may be vague feelings of unease, disconnection, sadness, or agitation. Cozolino states that “These symptoms are themselves forms of implicit memory; what the mind forgets, the body remembers...” (Cozolino, 2006, p. 131).

Clinical psychologist David Wallin (2007) states that in order to resolve issues from earliest childhood (those which occur prenatally up to 18 months) something other than verbal or cognitive therapy is required. Other clinicians agree, indicating that for some issues, talk therapy is neither adequate nor effective (Fosha, 2003; Scaer, 2001; Rothschild, 2000, 2010). Damasio (2000) and others state that traditional counselling is not effective because the residue of early stress or trauma is stored in the body and nervous system (Wilkinson, 2006; Rothschild, 2010; Levine, 2005, 1997; Johnson, 2002; Siegel, 2008; Ogden and Minton, 2006; Van der kolk, 1994). Therefore, to effectively resolve inaccessible or early childhood issues, the therapy must focus on where the memory is stored – the body and nervous system (Feldner et al., 2007).

## **Self Regulation Therapy® (SRT)**

One therapy that directly focuses on reducing the effects of stress and trauma on the body and nervous system is Self Regulation Therapy® (SRT). It is described as being a short-term, body-centered approach effective for treating symptoms such as anxiety, panic, depression, and dissociation. SRT therapists work with clients to reduce nervous system activation and enhance emotional, physical and relational functionality. Proponents of SRT claim it can reduce symptoms within a few sessions, and that “typically both improvement of symptoms and completion of treatment are attained in significantly less time than conventional therapies” (Lepage, p.1, 2004).

As a current practitioner of SRT, I have witnessed and personally experienced the effectiveness of Self Regulation Therapy. Clients have been very positive when I have used SRT in session, and the feedback has been that SRT was successful where no other therapy has been. Therefore, in developing my practicum, my focus was to work with SRT with a population typically outside my purview.

Perhaps as Field (2003) suggests, I was drawn to work with expecting and post-partum mothers because of my own early experience. I was also very cognizant of the inestimable toll PPD and PPA take on mothers and babies. I wanted to increase my experience and facility using SRT, and was curious about its utility on issues like attachment or anxiety. Ultimately, it is inconsequential which stimulus was more personally compelling. My practicum objective was to work

with women experiencing symptoms of pre-natal or post-partum anxiety or depression utilizing SRT.

### **Theory and Framework**

In an exploratory discussion on social work theory and user participation, Beresford (1999) intimates that theory and social work are sometimes seen as strange bedfellows, or at least, incompatible companions. Beresford states that social work theory is often more accurately defined by the service *approach* or technique the practitioner takes with the client, for example, family systems, solution focused, or anti-oppressive approach. In a general sense, the very role of social worker demands that we endeavour to be client centered and anti-oppressive, for to be otherwise would be contrary to the role of social worker. Reflecting personally, I consider myself to be not only anti-oppressive and person-centered, but also a post-modern feminist in the way I practice social work.

Perhaps more than any other, feminist theory makes the context and circumstances women live in, and the oppression they face primary. Post-modern feminists acknowledge the impact of context, but reject the idea of a singular truth for women (Ritzer, 2005). Post-modern feminists recognize that gender categories are social constructs which also constrict and oppress. “Postmodern feminism does not focus on the category “woman”. Rather, it focuses on the situated realities of women, plural” (Weisberg, 1993, p. 243).

Canadian feminist Judy Rebick states in her book: *Ten Thousand Roses: The Making of a Feminist Revolution*, that “one of the most powerful effects of feminism has been to open up our society to new kinds of relationships and new

ideas about family and gender rules" (2005, p. xiv). On a less optimistic note, Rebick notes that even as feminism has forged new ways of being in the world, patriarchy and oppression persists, sometimes more subtly, driven underground, but unabated. I believe the evidence of this subtle enduring oppression of women is evident in the prevalence of post-partum depression (PPD) and anxiety (PPA). There can be no argument that PPD and PPA are strictly women's issues.

For women, PPD/PPA are equal opportunity, in that they cut across social class, education, and racial lines. In my practicum I saw women who were in partnered relationships, but many were parenting alone. Some had ample financial means but the majority did not. There were middle class Caucasian women, those of Latin decent, as well as Aboriginal women - who comprised a slim majority. What unified these women was that they had borne children and were now struggling, typically alone, with feelings of hopelessness, helplessness, shame, and guilt.

These feelings of shame and guilt are ubiquitous to both PPD and PPA. These women consider it a personal failure or weakness. Consistently they reported a reluctance even to disclose their depression or anxiety to their doctors. In fact, women remind and 'warn' new moms that the public health nurse will be calling after baby is born to check for post-partum depression. They coach each other on how to respond so their mood instability is not revealed. Some moms revealed that they hide their feelings and do not disclose their thoughts to their partners, family members or even other women friends as they fear judgment. They are wary about revealing too much even to their doctors or counsellors, not so much because of

fear of judgment and scorn, but out of fear of losing their babies.

This shame and fear is not a reflection of progress but rather supports Ife's contention that for women, the struggle for human rights has been lost at the front door. He notes that on the domestic front, women "are the victims of human rights abuse on a massive scale. This is reinforced by feelings of shame, inadequacy and personal guilt, which is still widespread despite the best efforts of feminist groups to raise women's consciousness in this regard" (Ife, 2008, p.53). As noted, this pervasive sense of shame and failure causes many women to endure their depression and anxiety silently and alone, therefore often not receiving the support and services they require.

Providing support and access to a specialized service to women suffering PPD or PPA was the intent of my practicum placement. Unfortunately, approaching the work from a feminist perspective ultimately complicated and subverted the process. Creswell (2007) states that the goal in feminist research is "to establish collaborative and nonexploitative relationships, to place the researcher within the study so as to avoid objectification, and to conduct research that is transformative" (p.26). On the surface, the primary practicum objectives of providing and assessing the efficacy of a specialized therapy technique to women suffering post partum depression or anxiety were compatible with the feminist framework.

During the practicum, what I found was that my agenda was not always compatible with the client's. The feminist perspective, as well as social work generally, looks at clients in their environment, taking into consideration the impediments to health and wellness. In working with clients who had PPD or PPA

my objective of providing a specialized therapy was, at times, in conflict with what the client's primary needs were in session. Some of the clients referred were enduring lives of abuse, poverty and deprivation, and were struggling to parent despite this. When my agenda was provision of self regulation therapy, and theirs was concern over baby's father coming home - or not, or whether they had enough food to last the weekend, or whether their worker would cut off their benefits, we had a values clash. If I had followed my own agenda I would have been moving away from collaboration and transformation and toward exploitation and objectification. In ignoring the client's needs and satisfying my own, I would be replicating their experience of marginalization and deprivation.

Obviously a social work practicum which further oppresses and marginalizes the clients being served would have been unethical as well as highly disrespectful. As a feminist social worker it was incumbent upon me to embody the other values inherent to the approach by being aware of the power differential; conscious of my role and position; self-reflective about the experience; and finally, to negotiate outcomes that were mutually beneficial (Creswell, 2007). This re-assessment caused me to modify the provision of services within the practicum placement in order to remain anti-oppressive and client centered. I was still able to provide self-regulation therapy to some clients, but for others, the demand was first to address basic health determinants before moving to self-regulation. This issue will be revisited in the segment on challenges and recommendations.

## **Literature Review - SRT**

Rubin and Babbie (1997) urge social work researchers to endeavour to complete a comprehensive and extensive literature review on the subject being studied. They suggest thorough perusal of what others have found and published in the area, and that any gaps in the existing knowledge base be noted. In regard to literature and research on SRT, there were more gaps than published knowledge. If the available literature is an indication, this form of therapy is either veritably unrecognized or too new to have garnered significant attention.

The only directly relevant information that the writer was able to access was web sites of SRT practitioners, and the web site of the CFTRE (Canadian Foundation of Trauma Research and Education) which is the founding organization offering training in this therapy technique. Additionally, there was one article found in the local *Wholife Magazine* (Lepage, 2004). Beyond that, any specific mention of Self Regulation therapy referred not to the aforementioned therapy, but rather to the process of self regulation of breath and energy through relaxation (Chrissy & Company, 2007; Beck & Fernandez, 1998; and Sanders & Waldkoetter, 1997).

It is recognized that SRT is a relatively new therapy (information on the CFTRE website and in the practitioner training manual was copyrighted in 2003), but it seems to be very closely related to another body focused therapy called ‘Somatic Experiencing®’ (SE). The techniques sound identical, and SE is more prevalent in the literature, even being noted on Wikipedia, the on-line dictionary (2007), and in books by Rothschild, 2000; Scaer, 2001; Phillips, 2000; and Peter Levine, 1997, 2005 - who is the founder of SE. Like SRT, SE is heralded as being a

gentle, efficient (typically one to six sessions), approach to healing the residue of trauma. (Sierra Tuscon, Inc., 2007; Wikipedia, 2007; Levine, 1997, 2005; Phillips, 2000).

As noted, SRT and SE are both indicated for working with the residue of trauma in the system. Both are also noted for being gentle, body centered techniques which help clients feel more grounded and settled. The literature on these closely related therapies state they work by reducing or releasing held energy in the nervous system, which may be seen as stress or anxiety.

Simplistically this is described as being done by regulating the nervous system through ‘titration’ of activation or sensations felt in the body, ‘resourcing’ with comfortable and safe images or sensation, and eventually ‘discharging’ the held energy from the system (Levine, 1997; Rothschild, 2000; Wikipedia, 2007; Atherton-Reid, 2007; Phillips, 2000). When this is successful, the founders of SRT claim that “Once the nervous system is balanced, individuals are able to experience joy, closeness in relationships, and vitality and resilience in the body” (CFTRE, 2003).

Considering the dearth of research on the efficacy of SRT generally, obviously there is nothing published about its application to pre-natal and postpartum depression and anxiety. But, SRT’s proponents assert it is a fast, gentle and safe treatment technique that allows clients to work through intense content without being overwhelmed in the process. If the therapy was effective, it would allow expecting and new moms to feel calmer, more centered, and more resilient - and able to experience the joy, closeness and bonding they hope for with their baby.

## **Literature on Post-Partum Depression and Anxiety**

Lack of literature and research is not an issue when the focus is depression or anxiety. The statistics on these and other mental health issues are unequivocal. Mental health issues are increasing worldwide. In 2001 the World Health Organization (WHO) reported that depression and anxiety were two of the most costly and injurious disorders to individuals and to health systems in the world. Since that time neither prevalence nor cost has decreased. By 2020, depression and other mental health issues will become the second highest cause of disability in the world (WHO, 2001).

There is consensus that depression, anxiety and stress syndromes tend to be gendered issues which are more frequently diagnosed in women (WHO, 2001; Marano, 2003; Thara & Patel, 2006; Wiegartz & Gyoerkoe, 2009; Edhborg, Seimyr, Lundh & Widstrom, 2000; Cozolino, 2006; Bourne, 2000). Part of the higher incidence rate for females may be attributable in part to prenatal and postpartum depression and anxiety which obviously contribute to the general statistics, and just as obviously are gender specific (Cozolino, 2006).

Estimates on the pervasiveness of postpartum depression vary widely, ranging anywhere from 8 to 80% (Murphy, 2009; Edborg, Seimyr, Lundh and Widstrom, 2000; Wire Service Canada, 2008; Hill, 2008; Field, 2003). Additionally, Wiegartz and Gyoerkoe (2009) state that studies have shown that anxiety disorders pre- and postpartum are even more prevalent. Further connecting the two ailments, Wiegartz and Gyoerkoe cite research which indicates that women who experience anxiety during pregnancy are three times more likely to experience

postpartum depression (Wiegartz & Gyoerkoe, 2009). The estimates for both depression and anxiety may be understated, as researchers also suggest incident rates are much higher, but often go undetected and unreported (Wiegartz & Gyoerkoe, 2009; Hill, 2008).

Stating that prenatal and postpartum depression and anxiety only effect women is misleading and seriously misrepresents the problem. In the 1960's, attachment research by John Bowlby and Harry Harlow was already clearly indicating that initial relationships between caretaker and infant/child will have long-term, perhaps indelible impact on later social and emotional adjustment and functioning (Cozolino, 2006; Bowlby, 1973; Levine and Kline, 2007). Current research findings unequivocally state that when the primary caregiver (typically the mother) is depressed or anxious, it will negatively affect her newborn (Herman, 1997; Levine & Kline, 2007; Cozolino, 2006; Siegel, 2006; Tarkan, 2004; Rothschild, 2000; Field, 2003; Edhborg, M., Seimyr, L., Lundh, W. and Widstrom, A.M., 2000; Thompson, 2006). Further, researchers are now able to delineate all the ways that maternal mental health issues impact on the baby, even *prior* to birth.

The concern over the impact of the pre-natal environment is warranted because:

What happens from the fetal period until two years of age creates the blueprint that influences every system in the body from immunity to the expression and regulation of emotion, to nervous system resilience, communication, intelligence, and self-regulatory mechanisms for such basics as body temperature and hormone production (Levine and Kline, 2007, p. 34).

Levine and Kline indicate that even in utero, the mother's state of being is already affecting her unborn child. Research has shown that fetuses of depressed or anxious mothers are far more active and have higher levels of the stress hormone cortisol (Cozolino, 2006; Thompson, 2006). Active or stressed fetuses are often active and difficult to soothe babies (Cozolino, 2006; Field, 2003). In fact, Thompson (2006) states that studies have shown that after birth, the babies of mothers who were depressed "display a 'profile of dysregulation' for the first year of life: inconsolable crying, abnormally high levels of stress hormones, and disorganized sleeping patterns, among other things" (p. 128). This creates a potentially explosive cycle or feedback loop. An already stressed, depressed or anxious caregiver struggles with a baby who cries inconsolably and is difficult to soothe. The more stressed the caregiver becomes, the more stressed and difficult the infant becomes.

This cycle is one that can continue for years, perhaps even generations. Levine and Kline (2007) cite longitudinal research which indicates that anxiety that persists through pregnancy correlates with personality and somatic issues in infants that endure through adulthood. Thompson (2006) cites a 20 year longitudinal study by Weissman which revealed that "children of depressed parents showed a roughly threefold increase in vulnerability to a long list of psychiatric disturbances: anxiety disorders, major depression, alcohol and substance abuse, various kinds of antisocial behaviors and social impairments, panic disorders, and phobias. (The twenty year follow-up, published in January 2005, showed even more striking patterns)" (p. 114). Levine and Kline (2007) are emphatic. They state the first 33

months of life (which includes the prenatal period up to 24 months) are critical to development. A range of factors, including prenatal exposure to alcohol, drugs or nicotine, prenatal stress and mental health issues can compromise the infant's nervous system. They are unequivocal in the consequences, which they state range from behavioural, emotional, and intellectual detriments which span the life time.

Vitality, closeness, and joy are what new mothers expect during pregnancy and after their babies are born. Literature shows that for many new moms, this is not the experience they get. Often depression and anxiety surface long before pregnancy, and if depression and anxiety are present during and after pregnancy, the impact on the baby can last a lifetime. With such compelling research into the long term, intergenerational effects of maternal depression and anxiety, it is clear that expecting mothers require services which can adequately reduce or ameliorate their symptoms so they can have the pregnancy and birth conducive to health for both mother and child.

The data on pre-and postpartum depression is compelling, but the lack of data on the effectiveness of SRT led to the primary learning objective of my practicum. The purpose of the practicum was to explore whether SRT could provide significant relief to expecting and post-partum mother's symptoms in 6 to 10 sessions. In one of the only published articles on SRT, one of the founders of SRT, Dr. Lynne Zettl, claimed SRT could provide some reduction in symptoms "after a few sessions", and that "typically both improvement of symptoms and completion of treatment are attained in significantly less time than conventional therapies" (Lepage, p. 1, 2004). The assertion has been made that SRT is a quick,

safe, and gentle healing technique. My question was whether it would be effective in reducing PPD or PPA symptoms.

### **The Practicum Placement**

My practicum placement took place from January to April, 2010. I had a multi-program placement working with clients from: Healthy Mother, Healthy Baby (HMHB); Healthy and Home (H & H); and KidsFirst programs.

My original practicum objectives were:

- To partner with the Healthy Mother/Healthy Baby program, the Healthy and Home program, and the Maternal Mental Health program to identify expecting or post-partum women who have suffered trauma and/or depression and anxiety and who would benefit from self-regulation therapy to address presenting symptoms.
- To work with identified clients, offering 6 to 10 sessions of self-regulation therapy to reduce severity of symptoms and increase functioning.
- To work with identified clients, if appropriate, to enhance connection and attachment with babies through education around attuning to and regulating the nervous system.
- To expand my knowledge of services available to expecting and post-partum women who struggle with mental health issues.

My learning objectives were:

- To develop a protocol to effectively work with expecting and post-partum

women to reduce anxiety/depression and/or trauma symptoms using Self Regulation Therapy®.

- To further research Self Regulation Therapy and its application to this specific population.
- To gain further experience using Self Regulation Therapy in a clinical setting.
- To measure and assess efficacy of this therapeutic model with this population.

## **Agency Profiles**

### **Healthy Mother, Healthy Baby**

The Saskatoon Health Region website (2010) offers the following public information about the Healthy Mother, Healthy Baby (HMHB) program:

HMHB is a community based program designed to provide information, education, advocacy, and support services to pregnant women within Saskatoon who are experiencing risk factors such as:

- poor nutrition
- low income
- isolation
- substance use
- poor housing
- mental health issues
- abusive relationships.

The website notes that client services are offered by prenatal health nurses, prenatal outreach workers, and a nutritionist. Services are available in-home, at Saskatoon Collegiates, and at the West Winds Primary Health Centre. The program also offers milk and vitamin and mineral supplements to those who require, but can't afford them. The program mandate is "To promote optimal pregnancy outcomes and Healthy lifestyle choices by providing support and education to individuals in the context of their family and community (Saskatoon Health Region News Releases, 2010)

### **Healthy and Home Postpartum Support Program**

The Healthy and Home Postpartum Support Program (H & H) provides support to mothers following discharge from hospital. The program offers the following services:

- A breastfeeding center staffed by a certified lactation consultant.
- The Post Partum Support Line - manned by a registered nurse and available for support, education and advice.
- The Postpartum Depression Support Group (PPD group). The group meets weekly and has open intake, which means women can begin attending any time after assessment by the intake facilitator (Saskatoon Health Region News Release). Women may attend the PPD group for up to 26 weeks.

The H & H program is staffed by nurses and lactation consultants. Facilitation of the PPD group is shared by one nurse from the H & H program and one mental health care practitioner (social worker, therapist, psych nurse, etc). The mental health co-facilitator is not a dedicated position.

## **KidsFirst Saskatoon**

The Saskatoon Health Region website (2010) describes the KidsFirst program as a free program for first time pregnant women, or families with children under 5 who live in the following neighbourhoods: Pleasant Hill, Riversdale, Holiday Park, King George, Meadowgreen, and Confederation Suburban Centre. The program offers a variety of services including counselling, early learning, family support, and home visits. Clients can self-refer or be referred by other agencies if they have or are experiencing risk factors such as:

- Poverty
- low education
- lack of social supports
- family violence
- problem substance use,
- substandard housing
- limited coping skills
- under-employment
- food insecurity
- lack of involvement in their community (Saskatoon Health Region, 2010).

## **Practicum Planning**

Initially my proposal included taking referrals from HMHB, H & H as well as Maternal Mental Health (MMH). Currently when new moms have mental health issues which cannot fully be addressed within the PPD support group, they are

referred to either Mental Health and Addictions Services (MHAS) or MMH. MHAS tends to have a lengthy wait list (up to 6 months), although prioritized referrals will be seen sooner. MMH accepts referrals more quickly, but moms must be referred by physician. Unfortunately, at the time of my practicum, the lone psychiatrist working in the MMH program could only offer clinic time once a month. Due to the logistics the decision was made to primarily focus on clients from HMHB and H & H.

One of the challenges, and unexpected opportunities, of my practicum arose immediately around shortage of office space. Both the H & H and HMHB programs are located at the West Winds Primary Health site. Unfortunately, during my practicum there were no offices available for sessions with clients. In the search for an office, I met with the manager of the KidsFirst program. KidsFirst offered not only dedicated office space that I could use for the duration of my practicum, but also an invitation to include KidsFirst clients in my practicum - both of which offers I eagerly accepted.

### **Referral Process**

Home visitors, nurses, and outreach workers at HMHB, H & H, and KidsFirst were provided information about my practicum. They were given information to share with interested clients briefly explaining the service I was offering. The criteria for accessing service was either presentation of trauma symptoms, anxiety, or depression (pre or postpartum). Being located off-site from HMHB and H & H posed a challenge regarding getting referrals. For efficiency, it was decided that clients could call directly, or the home visitors could call with

contact information. Because I was co-located with KidsFirst, I received their referrals directly.

### **Accessibility**

For new moms, especially moms struggling with PPD or PPA, making services easily accessible was a serious consideration. For convenience, clients were offered sessions either in their homes, in my office at KidsFirst, or in an alternate location if required. If a client wanted to be seen at West Winds I was able to book an office on a session by session basis. This typically coincided with the client accessing childcare during the time it was available for the PPD group. We were also able to arrange childcare when spots were available at the KidsFirst daycare. When there were no daycare spots, KF had funding available for their clients for childcare. For further ease of access, KF was able to provide transportation money for moms to come to sessions, while H & H and HMHB provided bus tickets.

### **The Referrals/Moms**

In total, 31 women were referred to me during my practicum. Of those, 19 were referred by the HMHB program, 6 were H & H referrals, 5 were KidsFirst clients, and one mom came to me as a MMH referral through Centralized Intake at Mental Health and Addictions Services. Of the total women referred, 5 were never seen, though we had phone contact. Of these 5, 3 moms had scheduled appointments but never attended. The other 2 did not schedule any sessions.

Of the 26 women who were seen, the average number of counselling appointments attended was just over 3. The fewest sessions attended (excluding those who did not attend at all), was one, and the most sessions was 11. One client had all her sessions (6 in total) via phone. Phone sessions in this case were fitting considering this mom not only had a newborn, but was experiencing paralyzing anxiety and panic. A second mom had 4 of her 9 sessions by phone. Again this was reasonable - having a newborn impacts mobility and ability to schedule.

### **Client Demographics**

Among the 26 women I saw during my practicum, the average age was 27 years old. Frankly, I was surprised by this. I had expected to get more referrals for young moms. But, the youngest mom who was referred was 17, and the oldest was 42.

Of the 26 moms, 9 of them were first time moms or were expecting their first child. Of the remainder, 7 had 3 or more children.

The majority of the women (12) were parenting with their partner. Nine were single parenting, and 7 were living with parents or family members. 3 of the women who were parenting with a partner were also living with parents or other family. Living/parenting circumstances of 3 of the women were unknown to me.

The great majority of the women referred (23) lived on the west side of Saskatoon. Of those remaining, 2 lived outside of the city of Saskatoon, and 6 lived on the south or east side of the city. If we were only considering referrals from KidsFirst, the strong west side majority would be explained as the KF ‘area’ is primarily restricted to certain core west side neighbourhoods. But of the 31 women

referred, only 5 were KF referrals. The differential in area of residence is likely explained by the fact that the preponderance of referrals (19) was HMHB referrals. The HMHB program targets moms who are faced with risk factors which include low income and poor housing. In Saskatoon the majority of the accessible (i.e. somewhat more affordable) housing is on the west side of the city.

## **Services Provided**

Of the 31 women who were referred for SRT, I did ‘pure’ SRT, precluding all other therapy modalities, with 3.

### **Client #1**

This mom was referred by H & H. She was a first time mom, living with her baby and partner. She had attended the PPD group and found it supportive. She was seeing the psychiatrist from MMH and was on medication, but her symptoms of depression were not abating. She noted severe lack of motivation and a feeling of disconnection from her baby, family, and friends.

This client reported trauma in her childhood. She had received counselling in the past which she had found only moderately helpful. She was interested in working somatically as she was frustrated that she still wasn’t ‘over it’ despite her previous counselling. She noted she would recognize success when she felt less depressed, less ‘stuck’, and more motivated.

We met for a total of 12 sessions. Sessions were one hour in length, and most took place at West Winds, which she was familiar with. She also had previous

history with me, as I had co-facilitated the PPD group while she was attending. Her knowledge of me may have contributed to more trust or ease in our work together. This client had a number of good supports in her life but felt disconnected from them. She had also lost touch with her own resilience and strength. We worked to settle her feelings of activation and anxiety and reconnect her with her feelings of purpose. When she was able to feel stronger internally she noticed better boundaries and more energy. When our sessions ended she noted major reduction in her symptoms and better connection with family, baby, and her own emotions.

### **Client #2**

The second mom was referred by the HMHB program. She was expecting her second baby and was on leave due to severe prenatal anxiety and depression. She was seeing a midwife as well as a naturopath, but had not been able to reduce her feelings of panic. She had also accessed other therapy with limited success. She disclosed trauma around her first birthing experience, and noted initial issues in attachment after her baby was born. She held guilt as a result and was experiencing increasing fear that her upcoming birth experience would be traumatic. Her goal in our work together was to reduce both her residual guilt and trauma symptoms so she could have a more optimal birth experience with her second baby.

Client #2 and I met for exactly 10 sessions. We met for every session at my office at KidsFirst. In all of our sessions we worked with SRT. Midway through our work together the client began using a visualization/affirmation program at home. She had already noted a reduction in her activation/stress levels after our first few

sessions. She returned to work partial days as her anxiety decreased and her energy increased.

As often happens with SRT, once the system is settled repressed emotions arise. This can be unsettling for a client, but in SRT, emotions are processed like any other sensation - titrated so they don't overwhelm, and observed with curiosity and acceptance. As this client allowed the grief over her past birth experience to come up and move through she reported her feelings of guilt and anger decreasing as well.

Outside of sessions she began to set and maintain better boundaries with family members. She opened up to an acquaintance about her anxiety. She felt heard, understood and more connected. She found the courage to talk to her partner about her anger that he had not intervened during her birth experience. Working through this anger allowed her to draw closer to him again.

At this point in our sessions she had renegotiated not only her birthing trauma, but some of her relationship trauma as well. She felt more trusting of others and had more confidence in herself. She had a clear conversation with her partner about how she wanted her upcoming birth experience to be. She did the same with her doctor and mid-wife. Once she was able to do the above she reported feeling grounded, calm, and optimistic about her upcoming delivery. Our work together concluded just a few weeks before her due date.

### **Client #3**

The last of my 'pure' SRT clients was my youngest referral. At 17 she was

expecting her first baby and had been referred because she was experiencing intense emotions (primarily anger) which she wanted to regulate before baby arrived. We had 4 sessions together and she cancelled another 3 sessions due to illness. Despite her age, this client was surprisingly mature and responsible - seemingly more so than the 'adult' family member who had engaged in a physical altercation with her and then told her *she* had an anger problem.

Working with this client was challenging. She gave very little feedback outside of telling me that during our session she 'didn't feel much' and wasn't sure what should happen. She stated the sensation of SRT was 'weird', which is a fairly common assessment from the uninitiated. Yet, she persevered with sessions and was always conscientious about attending our appointments or giving notice if she had to cancel.

Though this client gave me no feedback as to whether our SRT sessions were helping, she did relay collateral information that her boyfriend had told her she was calmer and less reactive. As well she said she'd begun to get along better with her mother, whom she lived with. When our sessions ended this client looked visibly different - calmer and more serene, and reported feeling 'better'. Even her home visitor gave me feedback that she had noticed a significant change in her.

In this case there is much more ambiguity about whether the SRT was responsible for the symptom resolution. Perhaps this client's settling was related to hormones. Just as conceivably, the transformation in my second client could have resulted from time off work and daily affirmations. And maybe the first client just needed support and encouragement to take time and space for herself once a week

away from her baby.

There is no empirical way of ‘knowing’. In that way therapy is not an exact science. Yet Ife (2008) reminds us of the necessity to legitimize and recognize our *other* ways of knowing outside of empirical research. I have experienced and witnessed the sometimes startling transformations that SRT can generate. Therefore I am confident in my knowledge that, on some level, SRT *was* a factor in helping these three clients resolve their PPD, PPA, and trauma symptoms.

### **The Other Clients**

As noted, I was able to use a straight course of SRT with 3 clients. There were 5 clients I had no contact with. With another 3 clients my focus was strictly social work - advocacy, support, education, and connection. The remaining 20 clients seemed to fall into two groups - with half I used SRT in addition to talk therapy as the situation required. With the other 10 clients I used no technique at all outside of attempting to be a calming presence in midst of a chaotic life.

What I found with the latter clients was that when I sat with them and met them where they were, change still happened. Not in a sudden or dramatic way, but slowly and more subtly. Incrementally some of these moms settled and became more grounded. Despite being overwhelmed, some began moving out of paralysis into doing mode. Eventually they started asking for what they needed, even if that meant cancelling appointments. I noticed more focus on their babies as they began to ignore me and shorten our sessions. As these moms became more connected with their babies my services were made redundant in the best way possible.

This was the change I envisioned, but it did not evolve as I imagined. While I used SRT in some sessions, it was not the mainstay. Rather, my focus was on grounding, settling and helping mom attune to and respond to baby. I did this by simply and respectfully attuning to and responding to Mom in the moment. Together we acted out Wallin's (2007) assertion that change and development happens within the context of respectful, safe and supportive relationships. We also confirmed Duncan et al.'s (2004) theory that in some cases, technique contributes very little to the change process.

There were some clients who attended or booked few sessions. When we did meet, they seemed un-invested and there was little connection. They were not overly interested in SRT, or in any therapy. What they were concerned about was surviving another day. With getting to the food bank with no bus fare. With getting through the rest of the month until cheques came in. With where a partner was, and if he was coming home. Or why their worker had not returned their last 3 phone calls.

Working with these women did not teach me more about SRT, but it reminded me how to be a social worker. These clients were lacking *most* of the determinants of health. They were living in poverty, they had few supports, and they had no hope or promise that anything was going to get better. I was not surprised they were un-invested in SRT. It had nothing to offer. How could they work on becoming grounded or more settled when they were living in chaos? What I had to offer as a counsellor was valueless, when basic health determinants such as food security or safe housing were absent.

Though I had met many of my learning objectives, it was with surprise I realized that one of the most valuable lessons of my practicum wasn't related to practicing SRT. In fact, it arose from the clients that I did *not* specifically use SRT with. I had wanted to work with an unfamiliar population. I had wanted more facility with SRT. I wanted to help enhance attachment. And I was a social worker, doing a social work practicum.

In my practicum I was acting as a student, but also as a social worker. Ife (2008) acts as conscience reminding us that "...there can be no clear separation between social work education and social work practiced" (p. 160). The heart of being a post-modern feminist, anti-oppressive social worker is not only recognizing and respecting client's diversity and context, but also keeping their needs paramount. The moms referred had either experienced trauma or had symptoms of PPD or PPA. Many of them were also enduring poverty, abuse, food insecurity, and substandard housing. They had multiple needs, but receiving self regulation therapy because it satisfied my learning objectives was not one of them.

When I reflected on my practicum, I initially thought I had not fully met my learning objectives. I had not done SRT with *all* the moms referred; with some I had done social work. But, I realized that to force my agenda on clients who had more pressing issues would have been oppressive, disrespectful, and unethical. At the end of my practicum I relearned one of the most basic, inalienable social work tenets - "refrain from imposing values, views and preferences on clients" (CASW, 2005, p. 6).

## **Ethical Considerations**

During the practicum placement several situations arose which posed ethical challenges. The emergence of the ethical concerns gave rise to a more overarching issue - where would I take these issues to get them resolved? This was one of the complications of working multi-program. There was much cross-over, but my supervisors at HMHB and H and Hwere not social workers, and could not provide supervision around social work ethics. Similarly, the supervisor at KidsFirst was not a social worker. Though I could get feedback on social work ethics from both my academic and field supervisor, neither had knowledge of the agencies I was working with, so their input was restricted to theory. Ultimately, I combined theoretical information, information from the program, and informal supervision gained from colleagues to negotiate the issues I encountered.

The first ethical concern I was faced with arose *before* I began working and came to light as I wrote up my proposal. It was in the area of the provision of, and continuation of service. The women I was to work with were suffering from pre-natal or post-partum depression and/or anxiety, which, by definition, is often time limited and circumscribed to a predictable period of time before and after baby is born. The concern I had was what services could I guarantee would be available when my practicum ended? Typically when one does a practicum in an agency, at practicum end the clients are transferred to another clinician if they require further service. In my situation, there was no clinician within the programs who could continue the service afterward.

My practicum was designed to offer a limited number of specialized therapy

sessions to women who would not normally have timely access to that service. The goal for the clients was alleviation of symptoms so they could go through the birth process and/or parent afterward in a more settled and grounded way, therefore enhancing attachment and connection. Ideally that would happen within the maximum of 10 sessions I offered.

What we know as clinicians is that, often the presenting issue is only that - a symptom, representing deeper issues needing to be addressed. The concern was that rather than alleviating the presenting concern, my service might only 'rip off the scab', leaving a deeper wound requiring much more than 10 sessions to heal. Like physicians, social workers must also focus their work so they do no harm (Rubin and Babbie, 1997). To potentially ignite an emotional firestorm without considering a plan of how to extinguish same, bordered on unethical.

The solution to this dilemma was a typical social work one - being stringent about both establishing and maintaining the parameters of the work and the boundaries around doing it. This began with the informed consent I went over with referred clients. In delineating what follow-up services were available, as well as the waitlists for same (Adult Counselling at Mental Health and Addictions Services has a wait list ranging from 4 to 6 months) clients were able to make informed decisions around how deeply they were willing to go. As well, as the clinician, the onus was on me to keep the sessions focused and contained to the piece of work we were doing and to refer to another clinician if the need arose.

Another ethical issue that arose during the practicum was also around informed consent, but involved confidentiality. At the outset of any client

interaction, there is clear explication of the limits of privacy and confidentiality. There is emphasis on the limit to confidentiality if there is danger to self or other, especially a child (Rubin & Babbie, 1997). In this particular case, a mother was in crisis and reported to another health agency that her depression was so extreme she was concerned she might hurt her baby. *Subsequent* to that she was referred to the program I was working in. The mom disclosed that when she had been concerned she had taken steps to ensure both she and her baby were taken care of. She had followed through with her safety plan and now felt secure.

The issue in this case was that the health service she had presented to *had never reported the incident* although the Child and Family Services Act, Section 12 (1) clearly states an obligation to report any real or potential danger to a child (Government of Saskatchewan, 2006). Whether this was oversight or negligence, it left my agency in a dilemma. I and another worker were involved in providing service to this mom. Our knowledge that the incident was not reported left the onus on us to report to Child Protection. Having met with this mom, and knowing her present context, we felt this was *not* a situation where she was “at imminent risk of seriously harming themselves or others” (Rubin & Babbie, 1997, p. 63). Due to the ambiguity, we accessed supervision on our ethical obligations. After consulting with the program manager, the decision was made to err on the side of caution and ethics, and a call was made to the Ministry of Social Services (MSS).

Reporting this case to the MSS could have damaged a nascent therapeutic relationship at a time when, in my opinion, there was no longer any real or present danger. But, as often happens in therapy, the situation was utilized both as a

learning experience and to strengthen the trust and connection in therapy. I talked to the client at the next session about whether a report had been made. I explained that a report would be mandatory, and prepared her that MSS might contact her.

Naturally this caused initial alarm and distrust. I was able to reassure mom that, in this case, *if* the MSS got involved at all it would be to offer supportive service, rather than apprehend. When the client did not end up getting a call, let alone a visit from a child protection worker, her concern was assuaged, and she appreciated being forewarned about the situation.

This issue brought to light how often, as social workers, we rely on our knowledge of clients and trust in what we see, hear, and intuit. The statute which demands reporting of danger is sound and designed to protect rather than punish. And, by the letter of the law, the client should have been reported by the agency she disclosed to. Reporting after the fact seemed redundant and potentially punitive. Clients report frustration that when they ask for help they often feel punished by the system by being labelled as unstable, unfit, or inadequate parents. As social workers we attempt to negotiate the middle ground - ensuring safety and provision of service while working within ethical guidelines that are sometimes more relevant in theory than in practice.

The last ethical issue that arose came after my practicum was completed and I had returned to my position at Mental Health and Addiction Services (MHAS). This was a challenge to the first ethical dilemma I referenced - continuation of service. This situation aptly illustrated for me not only the chasm between theory and practice, but also the conflict which can arise between client need versus

program need.

At the conclusion of my practicum, one client who had accessed services from both the Kidsfirst program and Healthy and Home (attending the PPD group) felt she needed more service. I delineated the available resources to her and helped facilitate a referral to MHAS. The issue arose because the client knew I was returning to employment at MHAS and she wanted to continue service with me rather than transfer to another therapist. Unfortunately, this client did not demographically fit in the program I work within. I had conveyed that to her as we were concluding our sessions and she was told as much during the intake process. She was neither happy nor satisfied with this response.

At MHAS Intake there is a service policy that ‘No door is the wrong door’ when accessing services. Obviously endeavouring to give clients the service they require is vital. This client was requesting individual counselling services, and that was a legitimate request. But she was demanding the services be provided by a particular therapist and she did not fit the parameters of that program. I was returning to a case load that had been somewhat neglected in my absence, as well as clients who had been on a waitlist for several months. My program manager contemplated the request but the decision was made based on program need, not client preference. This client was being offered the services she requested, but not with the provider she requested.

Ife (2008) states it is a human right to receive the services required to be healthy and achieve one’s full potential. The Canadian Human Rights Act states that all individuals have the right to create “lives that they are able and wish to have

and to have their needs accommodated, consistent with their duties and obligations as members of society” (Minister of Justice, 2009, p. 1). Because this client was unsatisfied with the services offered, I encouraged her to advocate on her own behalf.

The client formalized her concern and negotiated the layers of the system, culminating in expressing her dissatisfaction to the President and CEO of the health region, Maura Davies. Attention was brought to the issue all down the hierarchy of the system. The final question coalesced to weighing out the wants/needs of the individual on one side, versus program policy on the other. In the end, the initial decision was overturned, and the client was again able to access services with me.

As social workers it is an ethical imperative to create and maintain healthy boundaries. It is crucial not only for our own practice, health, and well being, but also as a teaching and modeling example to our clients. Adding this client to my caseload would not have been injurious to me, but would mean others who had been waiting for service would wait longer. On a macro level, what was at issue were the boundaries and policies of a program designed to meet the needs of the many. On the micro level, were the needs of this client. The issue clearly delineated the conflict between theory, policy, and reality. Human rights notwithstanding, our present system cannot provide all service to every individual in the quality and quantity they may desire or require.

In social work, there are times when the dichotomy between need and policy is resolved by making a clinical assessment regarding outcomes. Ultimately, after self-advocating and negotiating the system, the client felt heard, understood

and respected - tenets of successful therapy. As a result, when we eventually resumed our work, the client only required a further 3 or 4 sessions. While this case may not be representative of how the system typically responds to need, on both micro and macro levels this case does reflect best practice outcomes.

### **Practicum Challenges**

In addition to the noted ethical dilemmas, I also encountered the following challenges and issues during my practicum placement:

- Lack of dedicated office space suitable for client sessions.
- Inability to be co-located with my team(s) due to above office space issue.
- Disconnection from team(s) due to being off-site.
- Loss of potential learning from the home visitors as a result of disconnection.
- Lack of on-site social work supervision and consultation.
- Exploring new territory - neither HMHB nor H & H had supported a social work practicum student before.
- Neither program had offered clinical counselling to clients so we were creating the program as we went along.
- Because the program was new, some home visitors were vague in their explanations to clients. I found a few clients were uncertain what to expect.
- Recording and charting requirements differed for each of the 3 programs.
- There were clients who overlapped in more than one program, but the separation of programs did not allow for fluid intercommunication.
- Brevity of the practicum impacted connection with clients. 3 ½ months was not

long enough to establish a firm foundation of trust and safety.

- Lack of funding for transportation in the HMHB and H & H programs created difficulty for some moms to attend sessions.
- Because I did not obtain ethics approval beforehand I was unable to do any testing or measurement. To gauge effectiveness of SRT, I was limited to client feedback and subjective assessment.

### **Discussion and Recommendations**

Fanning and McKay (2000) describe the deficit in wasted potential, suffering, and strain on resources that depression causes, and remind us that two out of three sufferers are women. *Three* out of three sufferers of postpartum anxiety and depression are women, but the defenceless casualty is also the infant who does not receive the emotional or physical foundation needed for future health and well-being. Instead, research indicates this child is likely to grow into an adult and parent who is also more predisposed to depression and anxiety (Fogel, 2009; Sroufe, Egeland, Carlson, and Collins, 2005). As this cycle is repeated generationally, PPD and PPE become the malignant gifts that keep giving. And, as is the case with most issues, action to ameliorate this issue must be taken on both the macro and micro levels.

Recently there has been national as well as local attention to the rights of the child and improving the living conditions of children. Jill Eisen (2009), in a CBC report, states that in Canada, one in 9 children lives in poverty. Eisen cites a UNICEF report which indicates that among the 25 richest countries, Canada tied

for last place in providing for children in the early years (Eisen, 2009). Yet, even as funding is allocated toward programs for children, parents struggle with increasing mental health concerns (Thara & Patel, 2006; Dulmus & Wodarski, 1997; UNA-Canada, 2010). The constricted focus on the health of children misses the mark, as a child's environment begins with and is totally attendant to the health and well-being of its primary caregiver - typically the mother. To provide a child with a healthy start in life, the mother's physical health is paramount, but her mental health is also crucial.

In Saskatoon there are services for expecting and postpartum women. These services tend to be medically focussed. In terms of mental health, if a woman can not afford to pay for individual counselling, she is relegated to a lengthy (six months on average) wait for services at Mental Health and Addiction Services. Women who live in the core neighbourhood are eligible for counselling and parenting support services through KidsFirst. Unfortunately, at the time of this writing, KidsFirst also had a long waitlist with approximately 100 families waiting for service.

In Saskatoon, expectant mothers can receive pre-natal health care and support from the Healthy Mother, Healthy Baby (HMHB) program, but those services conclude with the birth of the baby, and do not include counselling or therapy. Following HMHB, women can access service from the Healthy and Home (H & H) program, but it is also a time limited service and does not provide counselling outside of the Post-Partum Depression Support group and phone line. The only other mental health programming available is through the Maternal

Mental Health Program, which can provide therapy, but these services are severely limited as the lone psychiatrist working in the program is constrained to one day per month.

There were 14,465 live births in Saskatoon in 2009, which was a 17 year high (Information Services Corporation, 2010). If anywhere from 15 to 80% of new moms are affected by maternal mood disorders, these numbers are concerning. More worrisome is that “women are 23 per cent more likely to be admitted to a psychiatric unit in the 18 months after giving birth than at any other time in their lives” (Hill, 2008, ¶6). When one considers that, at least in the UK, suicide is the leading cause of maternal death (Hill, 2008) this situation moves from concerning to potentially calamitous. Even if the above numbers are not totally representative for Saskatoon, the above indicates a perilous deficiency in dedicated maternal health services.

Apart from the lack of dedicated resources, another perplexing issue is that the services that are available in Saskatoon historically have been distinct services - being managed, staffed and, in some situations, located independent of each other. This lack of integration is confusing when the Saskatoon Health Region has been moving toward amalgamation of services to provide clients with more accessibility and expediency. For whatever reason, this streamlining is not seen in the services for expecting and post-partum mothers. Instead under-resourced services remain separate and somewhat fragmented, with the client unable to move seamlessly through the system.

## **Program Funding and Integration**

We know that when a person is already stressed and overwhelmed, even one more complication can become an insurmountable obstacle. When a woman is expecting or has just delivered a baby, she needs ease and support in navigating the healthcare system. Maternal health services should be coordinated such that no matter where or when a woman enters the system she can easily access required services. Services must be designed to meet client needs, rather than clients having to adjust to limitations and deficiencies in the system. This requires that dedicated funding and resources be committed to maternal healthcare both on the national and local levels. While that may not seem fiscally practical, research has shown that prevention results in long-term savings - especially around an issue that can have effects on future generations (Murphy, 2009; Shonkoff, 2009; Levine & Kline, 2007).

## **Service Delivery**

In addition to dedicated funding, integrated maternal health services would also provide seamless service to new or expecting mothers. This would not only eliminate obstacles to service, but also enhance development of trust and relationship. Research has shown that regardless of the therapy technique or modality, alliance and confidence in the counselling relationship is crucial to therapy effectiveness (Wallin, 2007; Herman, 1997; Duncan, Miller, and Sparks, 2004; Graybeal, 2007; Miller and Duncan, 2000). Requiring a client to change providers because their 'time is up' disrupts and jeopardizes whatever stability and safety has been established (Herman, 1997; Rothschild, 2010). It would be ideal to

have maternal services in integrated, co-located, and readily accessible.

### **Modality and Orientation**

While the purpose of this practicum was to explore the efficacy of SRT with maternal anxiety and depression, what was found was that formation of a stable alliance with the client was requisite to therapy viability. Clinically, it is only once safety and trust have been established that a therapist should move to working on deeper issues (Herman, 1997; Rothschild, 2010; Fosha, 2002; Lewis, 2004; Levine, 1997; Johnson, 2002). Having said that, research shows that clinicians should be experienced and skilled in a variety of techniques and modalities (Fosha, 2001; Feldner et al, 2007; Graybeal, 2007), because client's issues and histories are as unique and diverse as the individuals themselves. Having a number of therapeutic options, including somatic therapies, allows clinicians the flexibility to respond effectively to whatever issue the client presents with. It would be advantageous to moms to have access to a therapist/practitioner who is not only versed in various talk therapies, (e.g.: cognitive behavioural, narrative, brief) but also in SRT or SE. Full therapeutic eclecticism would provide more opportunity for bio-psycho-social-spiritual healing.

While nurses, psychologists and other practitioners also draw from a wide variety of theories and orientations, social workers by training and experience are eclectic and contextual (Ife, 2008; Graybeal, 2007). Perhaps more than any other discipline social workers are trained to conceptualize the person in environment, and tailor treatment accordingly. As Graybeal (2007) states, social workers elevate client directed improvisation and responsiveness almost to an art form! Therefore,

to be multi-disciplinary and client focussed, Saskatoon maternal health care teams require at least one dedicated clinical social work position.

### **Stigma Reduction**

When considering the enduring stigma and accompanying shame that women report around maternal mental health issues, another recommendation is that there be continued attention to stigma reduction in this area. With the awareness that secrecy borne of shame can have enduring or even fatal consequences, it is imperative to be more open about the frequency of PPD and PPE symptoms. Not every woman will suffer symptoms, but if 15 to 80% experience *some* effects, there is an obvious need not only for acceptance and normalization, but for pro-activity.

On a macro level, a positive step toward stigma reduction would be more balanced media exposure. Our symbols of post-partum issues must not be restricted to Brooke Shields and some rare mother with post-partum psychosis who kills her baby. On a micro level, as women we need to speak more openly about our experience, and support other women to disclose about theirs. As individuals and social workers, when we make the private public (Ife, 2008), we will more effectively support moms in combating PPD and PPE. To remain silent is to be complicit in the oppression and ‘othering’ of mothers, contributing to their internalized feelings of guilt, shame, and inadequacy.

Considering the above, the recommendations arising from my practicum are:

- i. Increased attention and funding to women’s general health and well-

being.

- ii. Permanent funding dedicated to maternal mental health care in Saskatoon.
- iii. Integration of current maternal health services in Saskatoon Health Region.
- iv. Making available maternal health services more accessible (i.e.: remove time limits; geographic limitations; provide transportation; and make childcare available).
- v. Ensure there is a clinical social worker trained in both somatic and cognitive therapies on the maternal mental health team.
- vi. Focus on reducing stigma about maternal mental health issues at both the local, national, and individual levels.

Admittedly these recommendations may not be exhaustive or globally relevant. Rather, they reflect the issues impacting Saskatoon mothers, and are changes which would be beneficial to both mother and child.

## **Conclusion**

Kennedy states that “one of the most formative experiences that we all undergo is the experience of birth. It is becoming increasingly recognized that ...the nature of our arrival into the world is (are) fundamental to, and may have significant impact upon, our future development” (Kennedy, ¶1, 2001). Social workers have long known that our early attachment relationships are a determining factor in our future health and well-being. Personally I have experienced the toll post-partum depression can exact. Professionally I have witnessed the generational effect PPD and PPA can have.

As a practicing clinical social worker I am trained in various therapy modalities. One of those techniques is Self Regulation Therapy® (SRT). On a personal level I have experienced the benefits of SRT. As a professional I have observed the transformational effects this therapy can have. My practicum was a reflection not only of *praxis* - the integrating of theory, reflection and practice (Ife, 2008), but also the intersection of private/public issues that is so ubiquitous to social workers.

My practicum objective was to work with expecting and postpartum moms using SRT. I was curious whether SRT could assist in reduction of PPD/PPA symptoms, thereby averting attachment issues. What I learned had less to do with SRT, and more to do with social work. SRT did effectively resolve symptoms and is a valuable therapy technique *in conjunction with* other ways of working. I found that at times, especially when basic needs were not being met, the approach or style of therapy became irrelevant. What was required was to be empathetic, responsive,

and *present*.

As Ife (2008) states, we utilize our experience, training and learning to assess what the client needs and then attempt to provide that resource. What some of the clients needed within my practicum was not SRT, therefore reassessment was necessary. Fosha (2001) and Feldner et al. (2007), assert that no *one* technique will be sufficient to deal with the complexity and multi-faceted nature of what our clients present with. As Fosha (2001) states, “Only theories are pure and unimodal. People are messy and multimodal, complex and chaotic systems” (p. 2).

One of the observations arising from my practicum is that directing resources toward enhancing children’s health and well-being while ignoring the context they are born into is short-sighted and ineffectual. We know that:

What happens from the fetal period until two years of age creates the blueprint that influences every system in the body from immunity to the expression and regulation of emotion, to nervous system resilience, communication, intelligence, and self-regulatory mechanisms for such basics as body temperature and hormone production (Levine & Kline, 2007, p. 34).

We also know that if intervention occurs within the first 2 years of life, negative effects can be ameliorated (Cozolino, 2006; Levine & Kline, 2007; Shonkoff, 2009). It has also been shown that, “small financial and social investments at the outset will reap prodigious (and multi-generational) savings in areas of special education, social services, and the correction/legal system (Shonkoff, 2009).

On a macro level, whether the intervention is SRT or some other form of therapy that supports health is irrelevant. What is relevant is that as social workers

it is incumbent upon us to advocate for the financial and social investments necessary to support healing and health. This is an ethical imperative, because as Ife (2008) states, social workers advocate for increased services, “not just because they are a good idea, or would make people healthier, better educated, better housed, and so on. Rather, they are also arguing for them because it is people’s *human right* to receive adequate services in order to realise their full humanity” (Ife, 2008, p. 111, italics added). If we are to have a healthy society, we need to start at the beginning: healthy mothers - healthy babies.

*Individual trauma healing not only heals us, but our offspring as well. First we heal at the level of the personal, then at the level of family, then at the level of community, next at the level of nations - and finally at the global level* (Levine & Kline, 2007, p. 439).

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