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# Perinatal Mental Health Certification

## Postpartum Support International PMHC

**Version Demo**

**Total Demo Questions: 8**

**Total Premium Questions: 89**

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# Topic Break Down

| Topic | No. of Questions |
|---|---|
| Topic 1, Perinatal Mental Health | 28 |
| Topic 2, Perinatal Mental Health Disorders | 18 |
| Topic 3, Assessment and Diagnosis | 13 |
| Topic 4, Treatment and Interventions | 21 |
| Topic 5, Professional Practice, Ethics, and Legal Issues | 7 |
| Topic 6, Mix Questions | 2 |
| Total | 89 |

QUESTION NO: 1

19. Risk factors for postpartum depression include: (CHOOSE ALL THAT APPLY)

**A.** History of abuse

**B.** Marriage

**C.** History of mental illness

**D.** Concurrent life events

**E.** Giving birth to a male child

**F.** Red hair

**ANSWER: A C D**

**Explanation:**

“History of abuse,” “History of mental illness,” and “Concurrent life events” are established risk factors that should prompt careful perinatal mental-health assessment and support planning. A history of abuse, including interpersonal violence or trauma, can increase vulnerability to depressive symptoms during pregnancy and after birth through ongoing safety concerns, trauma-related symptoms, reduced social support, and stress. A personal history of mental illness is particularly clinically important: prior depression, anxiety, bipolar disorder, or other psychiatric illness increases the likelihood of a perinatal mood episode, and clinicians should ask specifically about past diagnoses, treatment, hospitalizations, medications, and prior postpartum symptoms. Concurrent life events—including relationship disruption, financial strain, housing instability, bereavement, illness, or other major stressors—can compound the substantial adjustment demands of the postpartum period. These factors are not diagnostic on their own; rather, they identify people who may benefit from earlier screening, closer follow-up, psychoeducation, and timely referral when symptoms emerge. Postpartum Support International identifies prior mental-health concerns, trauma, and stressful life circumstances as relevant considerations in perinatal mood and anxiety disorders. See Postpartum Support International’s information on depression during pregnancy and postpartum and ACOG’s guidance on perinatal mental-health screening and diagnosis.

**QUESTION NO: 2**

61. Case Study

Aliya is currently pregnant with her second child at 25 weeks gestation Her first child is 20 months old. She is coming to you to help her decide if what she is experiencing is normal for pregnancy or if she is having symptoms of a perinatal mood disorder. During her interview, she describes poor sleep, increased tearfulness, low energy, and irritability. She states that her first child sleeps well and is not interrupting her sleep, and that she is not waking up due to increased urination or physical discomforts of pregnancy. She reports that she has not ever been as tearful as she is now, including during her previous postpartum period She states that she has been tested by her obstetrician (OB) care provider for anemia and thyroid dysfunction and her lab results were normal. She is noticing that her irritability is affecting her relationship with her partner She worries that she is "pushing him away:" even though he is trying to be supportive.

Question: In the scenario. Aliya is describing increased tearfulness. Her symptoms occur daily for the last two weeks and are affecting her functioning. In addition to depressed mood, what other symptom would she need in order to meet the criteria of DSM-5 diagnosis of Major Depressive Disorder, with peripartum onset?

**A.** Anhedonia

**B.** Excessive guilt

**C.** Suicidal ideation

**D.** Psychomotor retardation

**E.** At least two additional qualifying depressive symptoms, for a total of five symptoms during the same two-week period

**ANSWER: E**

**Explanation:**

At least two additional qualifying depressive symptoms (for a total of five symptoms during the same two-week period) is correct. A DSM-5 major depressive episode requires five or more depressive symptoms present during the same two-week period, representing a change from prior functioning, with clinically significant distress or impairment. At least one of the symptoms must be depressed mood or markedly diminished interest or pleasure. In this case, tearfulness may support depressed mood, and the described poor sleep and low energy may support insomnia and fatigue. This amounts to three qualifying symptoms when each is confirmed as present most of the day, nearly every day. Therefore, two more qualifying symptoms must be established to meet the five-symptom threshold. Those additional symptoms could include diminished interest or pleasure, appetite or weight change, impaired concentration or indecisiveness, psychomotor change, feelings of worthlessness or excessive guilt, or recurrent thoughts of death or suicide. “With peripartum onset” is the DSM specifier used when the mood episode begins during pregnancy or within four weeks after delivery; it does not reduce the required number of major-depression symptoms. Careful assessment should also include severity, safety, functional impact, and differential diagnosis. See the National Institute of Mental Health overview of depression and Postpartum Support International’s information on perinatal depression.

## QUESTION NO: 3

During a private prenatal visit, a patient discloses using alcohol and cannabis to manage anxiety and sleep. Which actions are appropriate? (Select three.)

**A.** Explore use patterns, anxiety symptoms, safety concerns, and barriers to treatment without judgment

**B.** Discuss treatment options and offer a warm referral to appropriate substance-use and mental health services

**C.** Use supportive language that emphasizes the patient’s health goals and ability to seek help

**D.** Delay discussion of substance use until after delivery to avoid increasing anxiety

**E.** Use shame or threats of punishment to motivate immediate abstinence

## ANSWER: A B C

**Explanation:**

Appropriate care uses a nonjudgmental, person-centered approach that encourages honest disclosure and connects the patient with treatment and practical supports. The clinician should assess the pattern of use, co-occurring mental health symptoms, safety, withdrawal risk when relevant, and barriers to reducing use. A warm referral to substance-use and perinatal mental health services supports engagement. Shame, threats, and punitive responses can discourage prenatal care and do not address the underlying anxiety or substance use.

## QUESTION NO: 4

A perinatal clinician is meeting with a patient who has limited English proficiency and attends with a partner who offers to interpret. Which actions demonstrate culturally responsive and accessible care? (Select two.)

**A.** Arrange a qualified medical interpreter for the clinical discussion

**B.** Ask the patient how they prefer the partner to be involved in the visit

**C.** Use the partner as the interpreter because the patient arrived with them

**D.** Assume that translated written materials will meet all communication needs

**E.** Avoid discussing safety concerns to prevent cultural discomfort

## ANSWER: A B

**Explanation:**

The clinician should arrange a qualified medical interpreter and ask the patient about language, communication, and support preferences. A partner may be an important support person, but using a family member as the sole interpreter can compromise accuracy, privacy, and the patient's ability to discuss sensitive concerns such as depression, trauma, substance use, or interpersonal violence. Culturally responsive care avoids assuming beliefs or preferences from language, ethnicity, or family structure. Written materials should also be offered in an accessible language and format when available.

## QUESTION NO: 5

18. Including the support person in postpartum depression education creates a barrier to recognizing postpartum depression.

**A.** True

**B.** False

## ANSWER: B

**Explanation:**

**False** is correct. Including a partner, family member, or other trusted support person in education about postpartum depression generally promotes—not impedes—timely recognition and help-seeking. Symptoms such as persistent sadness, anxiety, irritability, hopelessness, sleep disturbance beyond expected newborn-related disruption, or thoughts of self-harm may develop gradually. A support person who understands warning signs can notice meaningful changes, encourage compassionate conversation, help reduce isolation and stigma, and support connection with appropriate clinical or community resources. Education should emphasize that perinatal mood and anxiety disorders are common, treatable health conditions rather than personal failures. It should also provide clear guidance about urgent safety concerns, including obtaining immediate emergency help when there is risk of harm to the birthing parent, infant, or others. Involving support people should occur with the parent's consent and with attention to privacy, safety, and family circumstances. Postpartum Support International identifies family and friends as important sources of support and offers information to help them recognize concerns and assist a loved one in obtaining care. The American College of Obstetricians and Gynecologists likewise supports screening and systems that ensure assessment, treatment, and follow-up for perinatal mental health conditions. See Postpartum Support International's family resources and ACOG's perinatal mental-health screening guidance.

## QUESTION NO: 6

21. Which behaviors would be exhibited during the letting-go phase of maternal role adaptation. Select all that apply.

**A.** Emergence of family unit

**B.** Dependent behaviors

**C.** Sexual intimacy relationship continuing

**D.** Defining one's individual roles

**E.** Being talkative and excited about becoming a mother

## ANSWER: A C D

**Explanation:**

The letting-go phase reflects the parent's integration of a new maternal identity into the broader family system. "Emergence of family unit" is correct because the mother and family begin reorganizing routines, responsibilities, and relationships around the infant, moving from the immediate recovery period toward a more stable family pattern. "Defining one's individual roles" is also correct because this phase involves accepting the changes associated with parenthood while renegotiating the mother's identity and the roles of other family members. This adjustment includes letting go of aspects of the pre-parenthood self and developing realistic expectations for life with the baby. "Sexual intimacy relationship continuing" is correct because the couple relationship is part of this family reorganization. As physical recovery, emotional adjustment, readiness, and clinical guidance permit, partners may gradually reestablish intimacy and incorporate their relationship as a couple into their new parenting roles. Postpartum adaptation is an ongoing process, and clinicians should support individualized pacing,

communication, recovery, and family adjustment. General postpartum care guidance emphasizes assessment of physical recovery, mood, sexuality, contraception, infant care, and family support during this transition. See the NCBI StatPearls overview of postpartum changes and ACOG guidance on postpartum contraception and sexual health considerations.

## QUESTION NO: 7

35. The nurse observes several interactions between a postpartum woman and her new son. What behavior, if exhibited by this woman, does the nurse identify as a possible maladaptive behavior regarding parent-infant attachment?

**A.** Talks and coos to her son

**B.** Seldom makes eye contact with her son

**C.** Cuddles her son close to her

**D.** Tells visitors how well her son is feeding

## ANSWER: B

**Explanation:**

**Seldom makes eye contact with her son** is a possible indicator of difficulty in early parent-infant attachment and warrants sensitive, nonjudgmental assessment. Eye contact is one form of reciprocal social engagement through which a parent notices and responds to an infant's cues; it often accompanies face-to-face interaction, soothing, and shared attention. When a postpartum parent consistently shows limited visual engagement with the baby, especially alongside emotional withdrawal, flat affect, limited responsiveness, or distress, the nurse should explore factors that may interfere with bonding. These can include depression, anxiety, trauma, exhaustion, pain, a difficult birth experience, feeding challenges, or limited support. A single observation does not establish an attachment disorder or diagnose a perinatal mental health condition. Instead, it identifies a need to observe the pattern over time, ask about the parent's experience compassionately, assess safety and mood symptoms, reinforce strengths, and connect the family with appropriate support. Postpartum Support International emphasizes that perinatal mental health concerns are common and treatable, and timely screening and referral can support both parent well-being and the developing parent-infant relationship. See Postpartum Support International: Learn More and the ZERO TO THREE parenting resources.

## QUESTION NO: 8

A breastfeeding parent with recurrent major depression has been stable for 2 years on an antidepressant. At the first postpartum visit, the parent says, "I am going to stop it today because any medication in breast milk must be harmful." Which response is BEST?

**A.** Encourage a prompt discussion with the prescriber about medication exposure, relapse risk, and feeding goals before making a change

**B.** Advise immediate discontinuation because breast milk exposure is always unsafe

**C.** Tell the parent that medication decisions should wait until breastfeeding has ended

**D.** Recommend reducing the dose independently whenever the infant feeds

## ANSWER: A

**Explanation:**

The best response is to support an individualized, shared risk-benefit discussion with the prescribing clinician before changing treatment. Medication exposure through breast milk must be considered alongside the medication's known benefits, the parent's history of recurrent illness and prior treatment response, infant factors, and the risks of relapse or untreated depression. Abrupt discontinuation can lead to withdrawal symptoms or recurrence. Breastfeeding goals are important, but they should not be addressed by automatically stopping an effective medication or by assuming that all medication exposure has the same risk.