

# EVALUATION OF A NURSE-LED INTERVENTION



TO EVALUATE  
POSTNATAL DEPRESSION AND  
CHILDBIRTH STRESS

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# EVALUATION OF A NURSE-LED INTERVENTION FOR POSTNATAL DEPRESSION AND CHILDBIRTH STRESS

## 1.0 EXECUTIVE SUMMARY

The birth of a baby is seen as a transition period for the family and, while wondrous and exciting, it often produces social, mental and physical health stressors for the mother and the family. Postnatal depression (PND) affects up to 20% of women and may alter the depressed woman's ability to nurture and care for her child with long-term ramifications on parenting skills and alteration in perception of childhood behaviour.

To address this situation the role of community health nurses, in the recognition and management of postnatal depression, is vital. Interventions related to health visiting have been highlighted in the literature as crucial in the prevention, early detection and management of depression in this period. However, there have been only limited randomised controlled trials that have addressed prevention of PND and further research is urgently required. As a result, this study aimed to evaluate a program to reduce the symptoms of postnatal depression and childbirth stress in women through a six-week structured home and telephone visiting intervention. A further objective of the study was to determine those women diagnosed as having clinical postnatal depression rather than childbirth stress.

A pilot study of 66 women who scored  $\geq 9$  on the routine Edinburgh Postnatal Depression Scale (EPDS) assessment, at the 6-8 week or 7-9 month child health assessment, were recruited into the quantitative study. Consenting participants were randomly allocated into two groups, the control group (A) or the intervention group (B). The control group was cared for as per current nursing practice (Pope & Watts, 1996) and the intervention group participated in a six-week manualised, structured home and telephone visiting intervention. All nurses were educated in advanced counselling and cognitive behavioural therapy techniques, including solution-focused therapy, in an effort to improve services for women with postnatal depression and childbirth stress. This educational program for nurses was a secondary objective of the study.

The nurse-led intervention was a collaborative initiative between community health nurses, the psychiatric consultation liaison nurse (PCLN), a psychiatrist and the mental health team at Fremantle Hospital. Participants in both groups were asked to complete a questionnaire that included demographic information, the Edinburgh Postnatal Depression Scale and the Ferrans and Powers Quality of Life Index (1985) at enrolment, following the intervention, and again three months following completion of the intervention. The Composite International Diagnostic Interview Schedule was used by the PCLN, at assessment, to assist in the women's diagnosis.

The results revealed that the average age of the study group was 31.6 years ( $SD=4.9$ ) with mothers' ages ranging from 19 to 42 years. Most of the mothers were married and 59% expressed satisfaction with their relationship, describing their partner as their main support. Although their babies ranged in age from four weeks to twelve months

the mean age of their infants was 16.5 weeks ( $SD=13.4$ ), with 61% of the sample in the first three months of life.

There were 33 participants in the control group and 33 in the intervention group. The Ferrans and Powers Quality of Life Index (1985) is a 68-item self-administered tool designed to measure (A) satisfaction with, and (B) importance of, several areas of life. These included health and functioning, socioeconomic, psychological/spiritual and family areas of the respondent's life. A six-point Likert scale measured from one 'very dissatisfied' or 'very unimportant' to six 'very satisfied or 'very important'.

Using an independent *t*-test to compare satisfaction with quality of life (A) scores between the control and intervention group, it was found that there was no significant difference in the mean score between the control and intervention group at screening ( $t=1.7$ ,  $df=57$ ,  $p=.08$ ), visit 1 ( $t=.92$ ,  $df=63$ ,  $p=.36$ ) or visit 2 ( $t=.57$ ,  $df=56$ ,  $p=.56$ ). Similarly the independent *t*-test to compare the importance of quality of life (B) scores between the control and intervention group, showed no significant difference in the mean score between the control and intervention group at screening ( $t=1.7$ ,  $df=62$ ,  $p=.08$ ), visit 1 ( $t=-.35$ ,  $df=63$ ,  $p=.72$ ) or visit 2 ( $t=.98$ ,  $df=63$ ,  $p=.32$ ). Comparison of the EPDS scores between the control and intervention group also found no significant difference in the mean score between the control and intervention group at screening ( $t=-1.2$ ,  $df=64$ ,  $p=.20$ ), visit 1 ( $t=.05$ ,  $df=63$ ,  $p=.95$ ) or visit 2 ( $t=.42$ ,  $df=63$ ,  $p=.67$ ). The findings demonstrate that there was no difference in the outcomes measured whether the clients were cared for according to standard practice or cared for using a specially designed structured home and telephone visiting program.

According to the findings of the Composite International Diagnostic Interview (CIDI) 45% of clients suffered from childbirth stress, 35% of the sample were diagnosed as clinically depressed by a psychiatrist and 20% were diagnosed with other medical or mental disorders. Thus, the study suggests that while some clients may have been tired, sleep deprived or anxious about parenting and suffered childbirth stress a significant proportion of the sample had a confirmed medical or mental health diagnosis.

However, univariate analysis approach to test the within-subject factor, satisfaction with Quality of Life (A), showed that the effect on Quality of Life (A) was significant ( $F=42.5$ ,  $df=2$ ,  $p<.000$ ). This indicates that there was a significant effect over time for both the control and intervention groups with improvements demonstrated in client's satisfaction with their quality of life. In contrast, the univariate analysis approach to test the within-subject factor, importance of Quality of Life (B), showed that the effect of Quality of Life (B) was not significant ( $F=.85$ ,  $df=2$ ,  $p=.42$ ). That is, the women's rating of the importance of several quality of life factors did not improve over time for either the control or intervention groups. In regard to the EPDS within-subject factor, the results showed that the effect of EPDS was significant ( $F=111.5$ ,  $df=2$ ,  $p<.000$ ). This suggests that, over time, participants EPDS score changed in a positive direction for both groups with client's experiencing reduced symptoms of depression.

Although the study failed to demonstrate a difference in outcomes between the control and intervention groups there was a significant difference in all participant's satisfaction with their quality of life and a decrease in their depression scores over the

three time points of the study. The research suggests that these positive outcomes are the result of the overall care provided by the community health nurses related to their advanced counselling skills and use of cognitive behavioural therapy and solution-focussed therapy techniques. It appears, for this sample, that the setting in which the care occurred did not influence a positive response from clients, however, the nurses' care, support and counselling did achieve significant results.



## **2.0 INTRODUCTION**

Developing interventions to meet the needs of clients with postnatal depression or childbirth stress is a challenge for community health nurses. However, it is important for practitioners to develop nurse-led programs in order to ensure clients have the best care available in the community. This randomised controlled trial evaluated the effectiveness of a structured home and telephone visiting program for new mothers at risk of postnatal depression and childbirth stress. The intervention and research was not without its problems and organisational challenges. The lessons learned, however, provide nurses with a clearer framework in caring for these clients in the community

## **3.0 BACKGROUND**

The birth of a baby is seen as a transition period for the family and, while wondrous and exciting, it often produces social, mental and physical health stressors (Cullinan, 1991). The high physical demands and emotional vulnerability experienced by new mothers in the postpartum often results in postnatal depression (PND) which is recognised as a significant health problem in about 10% to 20% of women (Romito, 1989).

Postnatal depression results in negative consequences for the mental health of the mother, the relationship with the infant and the overall health of the family (Cox, Murray & Chapman, 1993; Wrate, Rooney, Thomas & Cox, 1985). PND may affect the depressed woman's ability to nurture and care for her child with long term ramifications on parenting skills and alteration in perception of childhood behaviour (Holden, 1991; Armstrong, 1996; Seeley, Murray & Cooper, 1996).

It is widely accepted that the onset of PND tends to be gradual and consequently is not easily recognised, especially in the first six weeks after birth. In addition it is known in some cases to persist for many years, with serious adverse outcomes (Allan, 1993; Cox, Holden & Sagovsky, 1987; Pope, 1995). Armstrong (1996) highlighted the role of community health nurses in the recognition and management of postnatal depression and suggested health visiting was crucial in the prevention and early detection of depression in this period. Furthermore, previous research has demonstrated that specifically educated health visitors can have a significant impact on the depressed mothers' health and well being (Gerrad, Holden, Elliott, McKenzie & Cox, 1993; Cullinan, 1991; Holden, Sagovsky & Cox, 1989).

In Australia, there have been only limited randomised controlled trials that have addressed prevention of PND and further research is urgently required. Direct benefits to postnatally depressed women, in terms of improvement in symptoms of depression, have been demonstrated in two health regions in the UK with regular contact from health nurses trained in counselling and prevention interventions. Holden, Sagovsky and Cox (1989) used a controlled, random order trial to determine the effectiveness of health visitor counselling in the management of postnatal depression. The intervention involved eight weekly health visitor contacts to 50 clients who had been identified as depressed. Prior to the intervention, health visitor education sessions were conducted. Using the EPDS, results demonstrated that health visitor counselling management of non-psychotic depression was effective with a 32% difference in the full recovery rate between the control and treatment groups (69% in treatment group compared to 38% in control group). Even with the small sample size used in the trial, education of the

health visitors in counselling and identification of postnatal depression was well supported with the high number of depressed women's recovery rate.

Cullinan's (1991) replication of the Edinburgh study demonstrated a more profound improvement in the symptoms of women identified with postnatal depression. Six to eight contact visits from educated health visitors resulted in an improvement in 87% of the depressed women's symptoms ( $n=62$ ). Another health visitor intervention resulted in a 42% reduction in the EPDS compared to a 1% reduction in the pre-training control group (Seeley, Murray & Cooper, 1996). Egan's model of 'active reflective listening' and cognitive behavioural skills were included in the nurse education prior to the intervention. This study confirmed the success of a health visitor intervention in reducing the symptoms of postnatal depression in identified women.

As with many studies of postnatal depression (Seeley et al., 1996; Holden et al., 1993; Cullinan, 1991; Holden, 1991; Holden et al., 1989), the EPDS was used to identify high-risk clients in a three-group randomised controlled trial of alternative approaches to community follow-up. Seven hundred and eighty eight postpartum primiparous women confirmed that nurse-led telephone visits improved the health of postnatal women, especially the disadvantaged (Edwards & Sims-Jones, 1997). As a result, telephone visits have been introduced as a component of routine care for postpartum women in Canada.

In summary, it is recognised that postnatal depression is a significant health problem that negatively impacts not only the maternal-infant relationship but also the entire family unit. Noted in the literature, however, is a significant reduction in the symptoms of postnatal depression through home and telephone visits conducted by specially educated health professionals. It is this success which highlights the need for the current study to replicate, in an Australian context, an intervention using the multiple approach of education and counselling by specially prepared nurses.

#### **4.0 RESEARCH DESIGN**

The aim of this pilot research was to evaluate the effectiveness of a collaborative nursing intervention aimed at managing client's symptoms of depression. The primary objective of the study was to determine the effectiveness of a manualised, structured, telephone and home visiting nursing intervention to manage symptoms of postnatal depression and childbirth stress and increase the client's quality of life. A secondary objective of the study was to provide child health nurses with additional skills in counselling and cognitive behavioural therapy (CBT) techniques to improve prevention, detection and management of postnatal depression and childbirth stress.

##### **Sample and Sampling Methodology**

This randomised controlled trial evaluated the effectiveness of a nurse-led intervention, designed collaboratively by mental health and child health nurses working in the health service. All women at the 6-8 week or 7-9 month child health assessment were invited to participate in the study when they scored  $\geq 9$  on the routine Edinburgh Postnatal Depression Scale (EPDS) assessment (Appendix 1: Consent Form/Information Sheets). The exclusion criteria for the study included non-English speaking clients and women less than 18 years of age. Also clients who scored one or

more on item 10 of the EPDS, which is related to self-harm, were excluded (Appendix 2). Consenting participants were randomly allocated into two groups, the control group (A) or the intervention group (B). The control group was cared for as per standard nursing practice (Pope & Watts, 1996) but all nurses were educated in advanced counselling and cognitive behavioural therapy techniques. The intervention group participated in a six-week manualised, structured home and telephone visiting intervention conducted by nurses with the same advanced counselling and cognitive behavioural therapy education.

The research was conducted in 17 child health centres in the Fremantle area. Each has, on average, 15 clients per month for the 6-8 week or 7-9 month assessment. Based on an initial study into postnatal depression in the Fremantle Health Service with a sample size of 261, 17 clients (6.5%) in one month scored  $\geq 12$  (moderate to severe depression) on the EPDS (Downie, McGowan, Juliff & Wynaden, 1999; Downie, Wynaden, McGowan & Juliff, 2003) at these assessments. This significant problem required exploration and the search for best practice initiatives in community health nursing.

### **Instrument**

Outcome measures in the study included the EPDS and the Ferrans and Powers Quality of Life Index (1985). Participants in both groups were asked to complete these scales and demographic information at enrolment, following the intervention, and again three months following completion of the intervention (Appendix 3). The Edinburgh Postnatal Depression Scale is a 10-item self-report tool used to elicit responses from participant's concerning their feelings and experiences over the past week. The items are rated from 0-3 with a highest possible score of 30. The instrument has been shown to have satisfactory psychometric properties with split-half reliability of 0.88 and alpha coefficient of 0.87 (Cox et al., 1987; Murray, & Carothers, 1990). It has also been found to have satisfactory sensitivity of 86-100% and specificity of 78-93% (Fisch, Tadmor, Dankner & Dianmant, 1997). The Ferrans and Powers Quality of Life Index (1985) is a 68-item self-administered tool designed to measure satisfaction with, and importance of, several areas of life. These include health and functioning, socioeconomic, psychological/spiritual and family areas of the respondent's life. A six-point Likert scale measures from one 'very dissatisfied' or 'very unimportant' to six 'very satisfied or 'very important'. In the original sample of 349 randomly selected respondents there was a correlation of  $r=.76$  for the student group and  $r=.67$  for the patient group. Test-retest reliability revealed  $r=.87$  for the student group and  $r=.81$  for the patient group. Internal consistency measured by the coefficient alpha reported .93 for the Quality of Life Index.

### **Composite International Diagnostic Interview schedule**

The Composite International Diagnostic Interview (CIDI) (Appendix 4) schedule was developed in 1989 by the World Health Organisation and is a reliable and valid tool for assessing depression in clients. A psychiatrist trained the Psychiatric Consultation Liaison Nurse (PCLN) in the use of the tool to be used at the initial assessment. Inter-rater reliability for the tool was established. The psychiatrist supervised the use of the tool during the study and was the consultant to the research team in regard to the outcomes of the interviews. The psychiatrist made a diagnosis of clinical depression in relevant participants, based on this tool, during the study.

### **Education program for child health nurses**

All child health nurses (CHNs) involved in the study participated in two half-day workshops in preparation for the study (Appendix 5). This included further education related to PND, mental status and psycho-social assessment, counselling and listening skills education and the promotion of positive cognitive behavioural skills. A trained clinical psychologist and the mental health nurse involved in the study facilitated this education. In addition, CHNs were specifically educated in solution-focussed and cognitive behavioural therapy techniques over six, two-hourly sessions conducted at a private psychiatric clinic (Appendix 6). This ensured that the nurses in the health service had advanced skills to care for clients with postnatal depression and childbirth stress. However, it was important to determine if this care was better implemented using a very structured method of home and telephone visiting or via care through routine appointments in the Child Health Clinic (CHC).

### **The intervention**

Following enrolment into the study intervention clients were asked to make an appointment to return to the CHC within a week to meet with the child health nurse and the PCLN for further assessment (Appendix 7: Postnatal Assessment & Management Plan). During the appointment, a workbook (Appendix 8: Workbook) was given to each client outlining information on postnatal depression, the role of the child health and mental health nurses, strategies to improve their quality of life and a mood scale. This provided opportunities for the client to reflect and document their daily experiences, at home, of coping in the postnatal period. The first home visit was conducted in the second week and further education on postnatal depression, counselling, anticipatory guidance and discussion of the client's reflective journal and evaluation of the client's experiences during the past week were elicited. As part of the education session, a video on postnatal depression was shown to the client in their home. In week three a follow-up telephone call (Appendix 9: Telephone Interview Schedule) by the child health nurse monitored the client's progress and determined the need for further education, counselling and support. The call lasted no longer than 15 minutes and used a structured telephone visit schedule prepared by the researchers. Before terminating the call an appointment was made with the client to home visit the following week. During the second home visit the child health nurse focussed discussion on normalisation of the postpartum period and promotion of positive cognitive styles. The workbook continued to provide the framework for this discussion and further education. In the fifth week of the intervention another follow-up telephone visit by the child health nurse monitored the client's progress. In the final week of the intervention further support and education was offered to the client during a clinic visit.

The collaborative nature of the intervention, between child health and mental health nurses, ensured the client had the on-going support of a health professional with whom they already had a trusting relationship and the expertise of a specialist mental health nurse. At any time during the home or telephone visits, if the child health nurse was concerned about the client, liaison with the mental health nurse occurred.

## 5.0 RESULTS

### Sample Characteristics

In the sample of 66 participants, the average age of the study group was 31.6 years ( $SD=4.9$ ) with mothers' ages ranging from 19 to 42 years. Most of the mothers (81.5%) were married and 59% expressed satisfaction with their relationship, describing their partner as their main support (84%). Sixty-five percent were Australian born and 58% had partners who were Australian. Mothers described themselves as home-makers in 81% of cases. Of the overall sample 14% had previously been diagnosed with a mental illness and 24% were currently taking anti-depressant medication. Although their babies ranged in age from four weeks to twelve months the mean age of their infants was 16.5 weeks ( $SD=13.4$ ), with 61% of the sample in the first three months of life.

Overall, the Edinburgh Postnatal Depression score mean for the sample was 13.5 ( $SD = 3.4$ ) with scores ranging from nine to 25 out of a possible total of 30. The Ferrans and Powers Quality of Life Index (1985) scores increased from  $M = 18.7$  ( $SD = 4.5$ ) at visit 0, to  $M = 21.5$  ( $SD = 4.6$ ) at visit 1 and  $M = 23.1$  ( $SD = 3.9$ ) at visit 2. The scale was further divided into four sub-scales; health and functioning, social and economic, family and psychological/ spiritual. On all sub-scales the participants mean scores increased across the three time points demonstrating a positive change in their quality of life (Table 1).

**Table 1. Mean ( $SD$ ) for the four sub-scales of the Ferrans and Powers Scale**

	Screening <i>M</i> ( <i>SD</i> )	Visit 1 <i>M</i> ( <i>SD</i> )	Visit 2 <i>M</i> ( <i>SD</i> )
Health and functioning	18.1 (4.9)	21.0 (5.1)	22.8 (4.0)
Social and economic	19.6 (4.6)	21.8 (4.3)	22.6 (4.8)
Family	21.9 (5.1)	23.7 (5.2)	25.3 (3.7)
Psychological/Spiritual	16.7 (5.9)	20.8 (5.3)	22.3 (4.5)

The findings of the Composite International Diagnostic Interview (CIDI) revealed that 45% of clients suffered from childbirth stress, 35% of the sample were diagnosed as clinically depressed by a psychiatrist and 20% were diagnosed with other medical or mental disorders, such as anaemia, liver disease, psychosis etc.

### Control and Intervention Group

Of the 66 participants, there were 33 in the intervention group and 33 participants in the control group. Using an independent *t*-test to compare the quality of life (A) scores between the control and intervention group, it was found that there was no significant difference in the mean score between the control and intervention group at screening ( $t=1.7$ ,  $df=57$   $p=.08$ ), visit 1 ( $t=.92$ ,  $df=63$ ,  $p=.36$ ) or visit 2 ( $t=.57$ ,  $df=56$ ,  $p=.56$ ). Table 2 shows the mean quality of life (A) scores at screening, visit 1 and visit 2 for the control group and intervention group.

**Table 2. Mean (SD) Quality of Life Scores (A) scores over time for control and intervention group**

Study Group	Screening	Visit 1	Visit 2
Control (n=33)	4.3 (.91)	4.6 (.97)	4.9 (.73)
Intervention (n=33)	3.9 (.63)	4.4 (.78)	4.8 (.52)

The results from testing the between-subject effect, study group, showed that there was no significant difference in the Quality of Life (A) scores between the two study groups ( $F=1.6$ ,  $df=2$ ,  $p=.20$ ). The univariate analysis approach was used to test the within-subject factor, Quality of Life (A), and the interaction of within-subject factor and between-subject factor, Quality of Life (A) and study group (Mauchly's test of sphericity was not significant,  $p=.42$ ). The results showed that the effect of Quality of Life (A) was significant ( $F=42.5$ ,  $df=2$ ,  $p\leq .000$ ), however, the Quality of Life (A) and study group effect was not significant ( $F=1.9$ ,  $df=2$ ,  $p=.14$ ), indicating that the intervention had a significant effect over time but there was no difference between the control and intervention groups.

Using an independent  $t$ -test to compare the quality of life (B) scores between the control and intervention group, it was found that there was no significant difference in the mean score between the control and intervention group at screening ( $t=1.7$ ,  $df=62$ ,  $p=.08$ ), visit 1 ( $t=-.35$ ,  $df=63$ ,  $p=.72$ ) or visit 2 ( $t=.98$ ,  $df=63$ ,  $p=.32$ ). Table 3 shows the mean Quality of Life (B) scores at screening, visit 1 and visit 2 for the control group and intervention group.

**Table 3. Mean (SD) Quality of Life Scores (B) scores over time for control and intervention group**

Study Group	Screening	Visit 1	Visit 2
Control (n=33)	5.4 (.37)	5.3 (.89)	5.5 (.42)
Intervention (n=33)	5.1 (.82)	5.3 (.44)	5.3 (.71)

The results from testing the between-subject effect, study group, showed that there was no significant difference in the Quality of Life (B) scores between the two study groups ( $F=1.0$ ,  $df=2$ ,  $p=.37$ ). The univariate analysis approach was used to test the within-subject factor, Quality of Life (B), and the interaction of within-subject factor and between-subject factor, Quality of Life (B) and study group (Mauchly's test of sphericity was not significant,  $p=.32$ ). The results showed that the effect of Quality of Life (B) was not significant ( $F=.85$ ,  $df=2$ ,  $p=.42$ ). The Quality of Life (B) and study group effect was also not significant ( $F=1.2$ ,  $df=2$ ,  $p=.30$ ), indicating that the intervention was not significant over time in altering the QLI (B) and that there was no difference between the control and intervention groups in this regard.

Using an independent  $t$ -test to compare the EPDS scores between the control and intervention group, it was found that there was no significant difference in the mean

score between the control and intervention group at screening ( $t=-1.2$ ,  $df=64$   $p=.20$ ), visit 1 ( $t=.05$ ,  $df=63$ ,  $p=.95$ ) or visit 2 ( $t=.42$ ,  $df=63$ ,  $p=.67$ ). Table 4 shows the mean EPDS scores at screening, visit1 and visit2 for control group and intervention group.

**Table 4. Mean (SD) EPDS scores over time for control and intervention group**

Study Group	Screening	Visit 1	Visit 2
Control (n=33)	12.9 (3.2)	7.7 (5.8)	5.8 (4.0)
Intervention (n=33)	14.0 (3.6)	7.6 (4.6)	5.4 (3.2)

The results from testing the between-subject effect, study group, showed that there was no significant difference in the EPDS scores between the two study groups ( $F=1.2$ ,  $df=2$ ,  $p=.30$ ). The univariate analysis approach was used to test the within-subject factor, EPDS and the interaction of within-subject factor and between-subject factor, EPDS and study group (Mauchly's test of sphericity was not significant,  $p=.43$ ). The results showed that the effect of EPDS was significant ( $F=111.5$ ,  $df=2$ ,  $p\leq .000$ ). The EPDS and study group interaction, however, was not significant ( $F=1.1$ ,  $df=2$ ,  $p=.31$ ), indicating that the intervention was significant over time in altering the participants EPDS score in a positive direction but there was no difference between the control and intervention groups.

## 6.0 DISCUSSION

Depression after childbirth may have long-term effects on the woman, her partner and family potentially impacting the child's social, cognitive and emotional development (Holden, 1991). Therefore, strategies to prevent, detect and treat postnatal depression and childbirth stress are imperative.

In the current study the education of nurses to increase their skills in advanced counselling and assist clients through communication, listening and supportive interventions appears successful and is an approach used previously with success. For example, beneficial outcomes have resulted from training health professionals in the areas of postnatal depression aetiology, medications, understanding the father's role, counselling and listening skills and use of the EPDS (Ward, 1999). Furthermore, previous research also shows health visitors became more knowledgeable about the detection, treatment and prevention of postnatal depression and more confident in liaising with other health professionals following such education (Ward, 1999). This is congruent with the current study that highlights measurable outcomes for clients improved significantly when cared for by nurses educated in postnatal depression, solution-focussed therapy and cognitive behavioural therapy skills. Results of the study suggest that symptoms of depression were reduced and clients expressed improvements in satisfaction with their quality of life after counselling through the structured home and telephone visits as well as during routine clinic visits facilitated by specially prepared nurses.

An Australian study comparing the outcomes of women cared for by nurses trained in the use of cognitive behavioural therapy (CBT) techniques with those women

receiving 'standard care' found that nurses can effectively provide a modified CBT intervention in the treatment of PND (Prendergast & Austin, 2001). Similarly, the current study supports counselling sessions from child health nurses educated in CBT and solution-focussed therapy.

Although the current study did not show a difference between the outcomes of the two groups, structured home and telephone visiting or routine clinic visits, improved outcomes were noted in both groups. Additional education for community health nurses, to complement their already advanced communication skills, is seen as a positive step toward nurses expanding their role with postnatally depressed clients. This is important because it is often the nurse who is the first point of contact for the client and the established relationship shared by the client and nurse is a solid foundation for treatment.

It is clear that emotional support and early intervention using the EPDS leads to lower rates of PND as shown in a three centre training program in the UK. The study also confirmed the importance of links to other services (Holden, 1991). Similarly, collaborative links with the mental health team, which was an integral component of the current study, supports this previous research. The knowledge and skills of the experienced mental health team, building on the established trust between the child health nurse and client, meant that identification, early intervention, support and monitoring of the client with symptoms of PND or childbirth stress was readily available.

In contrast to previous research, the current study revealed almost 60% of PND participants expressed satisfaction in their relationship with their significant other. This is incongruent with the claims of other researchers who have reported that challenging life conditions, deficient social support networks and difficulties in the marital relationship are repeatedly linked with maternal depression (Terry, Mayocchi & Hynes, 1996; Neter, Collins, Lobel & Dunkel-Schetter, 1995). Findings in the current study may be explained by the limited questions asked about marital satisfaction and social support with this area only superficially addressed in the research.

Although there was no difference between the two study groups with respect to 'Quality of Life', the research shows that overall clients' *satisfaction* with their quality of life was significantly improved at the completion of the three-month study period. There was, however, no change in clients' perception of the *importance* attributed to quality of life items. This seems reasonable because as the symptoms of depression lifted, clients appear to have expressed an increased sense of wellbeing in regard to their satisfaction with life. The change to their depressive symptoms, not surprisingly, did not alter their underlying values concerning the importance placed on various quality of life issues.

Furthermore, in both the intervention and control groups, the findings show that clients' symptoms of depression were significantly reduced at the end of the study period, as measured by the EPDS. This indicates that the early intervention by the upskilled nurses, both in the structured home and telephone visiting program and the clinic, assisted and supported clients to improve their mental health. This supports the research, conducted in the UK, that found health visitor counselling by health professionals specially educated in CBT and use of EPDS increased staff confidence



and improved outcomes for postnatal clients (Holden, 1991; Seeley, Murray & Cooper, 1996).

It could be argued that as 61% of the women in the study had babies three months or younger their symptoms of depression may have resolved spontaneously over the study period without an intervention. Research shows, however, that this is not usually the outcome as some cases of postnatal depression continue for many years if left untreated and unresolved (Najam, Andersen, Bor, O'Callghan & Williams, 2000). According to the findings of the Composite International Diagnostic Interview (CIDI) in the current study, only 45% of clients suffered from childbirth stress, 35% of the sample were diagnosed as clinically depressed by a psychiatrist and 20% were diagnosed with other medical or mental disorders. Thus, the study suggests that while some clients may have been tired, sleep deprived or anxious about parenting a significant proportion of the sample had a definitive diagnosis. All clients require identification and treatment of postnatal symptoms with support, counselling and intervention by educated nurses resulting in satisfactory outcomes in the current study.

In summary, although the study failed to demonstrate a difference in outcomes between the control and intervention group there was a significant difference in the participant's satisfaction with their quality of life and a decrease in their depression scores over the three time points of the study. It is suggested that these positive outcomes are the result of the overall care provided by the community health nurses related to their advanced counselling skills and use of cognitive behavioural therapy techniques. It appears, for this sample, that the setting in which the care occurred did not influence a positive response from clients but the care provided by specially educated nurses was significant in improving outcomes.

### **Limitations and Recommendations**

One of the main limitations of the study design was that ultimately the intervention and control groups were too similar, with all nurses having received cognitive behavioural therapy and solution-focussed therapy education which therefore benefited all clients. However, given the needs of the health service to have all nurses educated in advanced counselling skills, and the desire to replicate previous research using the proposed approach, the current pilot study design was appropriate and provides a solid foundation on which to plan further research. One additional unexpected difficulty in the research was that the data collection period took much longer than initially anticipated, with the potential for bias. This problem occurred, not surprisingly, because the depressed women found it difficult to decide whether or not to participate in the research. For the main study, planned for the future, a more complex study design to minimise the potential confounding variables will be introduced. As the pilot study design involved randomisation of the sample, confounding variables were controlled, however, the use of antidepressant medication by participants during the period of the study highlights the caution necessary in interpreting the results.

One problematical issue addressed early in the study was the nurse's inappropriate compliance with the standard protocol (Pope & Watts, 1996). This was resolved at the commencement of the research project with education provided to nurses in the health service at clinical meetings. This ensured the consistency of standard care but is

obviously an avenue of potential bias in the study. Development of a self-paced learning package, to update nurses in use of the EPDS, was a further innovation in the study protocol to address the longer than expected time for sample recruitment and the high turnover of staff during this period. Factors such as these have the potential to influence the study results and will therefore be carefully taken into consideration in the design of future studies.

It is clear that postpartum depression and childbirth stress is a major mental health issue. Further research is needed to test interventions that may assist to alleviate the symptoms of depression. It is recommended that a future study be designed with inclusion of a third group to test the placebo effect of social interaction in home visiting, as a factor in improvement in outcomes. More distinction between the intervention and control groups is also warranted. Cognitive behavioural therapy techniques and solution-focussed therapy by nurses appear to influence a reduction in the symptoms of depression and improvements in the quality of life. This is an important finding from the current research and is encouraging in the implementation of nurse-led, evidence-based interventions to assist in the care of clients with postnatal depression and childbirth stress.

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## **8.0 APPENDIX 1: Information Sheet & Consent Form**

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## FREMANTLE HOSPITAL and HEALTH SERVICE

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### Fremantle Hospital & Health Service Community and Child Health Services

#### Information Sheet

#### Evaluation of an intervention to manage symptoms of postnatal depression and childbirth stress

My name is Jill Downie and I am a nurse and the chief investigator in a study that is looking at the management of postnatal depression and childbirth stress.

#### NATURE AND PURPOSE OF THE STUDY

You are invited to participate in a study that will help to determine if advice, assistance and education provided by Child and Mental Health Nurses can improve the management of symptoms of postnatal depression and childbirth stress. Child and Mental Health Nurses and a Consultant Psychiatrist have developed a six-week structured program that provides mothers with advice, education and practical ways to deal with the problems associated with postnatal depression and childbirth stress. This study has been approved by the Fremantle Hospital and Health Services Human Research Ethics Committee.

#### WHAT WILL THE STUDY INVOLVE

The reason you have been invited to participate is because you have scored greater than 9 on a routine screening questionnaire (the Edinburgh Postnatal Depression Scale). This indicates that you are at risk of developing postnatal depression or childbirth stress. If you agree to participate in the study you will be assigned by chance (like the flip of a coin) to either the current practice, where you will be referred to another health professional for assistance, or you will be asked to participate in the new six-week structured program. That is, there is a 50% chance you will receive the current practice and a 50% chance you will be assigned to the new six-week structured program.

If you are assigned to the six-week program you will undergo further assessment (this will require you to attend the Child Health Clinic for approximately 1½ hours), additional education, counselling and support via weekly home or telephone visits from the Child Health Nurse. The home visits will be audio-taped to ensure that the quality and consistency of the information provided by the nurse is consistent. If at any time during the program the Child Health Nurse believes you need additional help from another health professional you will be referred to the appropriate person.

Mothers in both groups will be asked to complete a questionnaire at the commencement of the study. The questionnaire measures your satisfaction with, and the importance of, several areas of your life. This questionnaire, along with the Edinburgh Postnatal Depression Scale will be repeated at six weeks and three months.

## **VOLUNTARY PARTICIPATION AND WITHDRAWAL FROM THIS STUDY**

Your participation in this study is entirely voluntary. If for any reason you wish to withdraw from the study you may do so without it affecting your current or future medical or nursing care in any way.

At no time will you be identified by the information you have given and any reports or articles written concerning the outcomes of the study will protect your confidentiality. Each participant will be allocated a code (a number) thus identification of surveys by name will not occur. The allocated code will be secured by the researcher and kept separately from identifying information thereby ensuring confidentiality. The information obtained during the study (including the tape recording) will be stored in a locked cupboard during the study period. At the end of the study period the tape will be erased. All data will be stored in a locked cupboard at Fremantle Hospital and Health Service for five years after the completion of the study and then destroyed.

This research is significant in that it will help child health nurses to identify and assist women at risk of postnatal depression and childbirth stress. If you have any questions, or require any further information before agreeing to participate in the study, please talk to the Child Health Nurse or contact me on (08) 92663024. In addition, if you have any complaints or concerns about the conduct of this research you may contact the Chairman of the Fremantle Hospital & Health Service Human Research Ethics Committee on 9431 2929.

Thank you for taking the time to read this information sheet.

Jill Downie, R.N., PhD  
Chief Investigator

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**FREMANTLE HOSPITAL and HEALTH SERVICE**

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**Fremantle Hospital & Health Service  
Community and Child Health Services****Consent Form**

TO BE USED IN CONJUNCTION WITH THE INFORMATION SHEET

**Evaluation of an intervention to manage symptoms of postnatal  
depression and childbirth stress**

Client's name:..... Date of Birth:.....

1. I agree entirely voluntarily to take part in the above named research study conducted by Dr. Jill Downie, Research Consultant in Community and Women's Health. I am over 18 years of age.
2. I have been given a full explanation of the purpose of this study, of the procedures involved and of what will be expected of me.
3. I agree to inform the nurse or the investigator of any undue stress that I may experience as soon as possible.
4. I understand that I am entirely free to withdraw from the study at any time and that this withdrawal will not in any way affect my future standard or conventional treatment or nursing or medical management.
5. I understand that the information in my medical records is essential to evaluate the results of this study. I agree to the release of this information to the research staff on the understanding that it will be treated confidentially.
6. I understand that I will not be referred to by name in any report concerning this study. In turn, I cannot restrict in any way the use of the results that arise from this study.
7. I have been given and read a copy of the Informed Consent Form and Information Sheet.

Clients Signature..... Nurses signature.....

Name (PRINT)..... Name (PRINT).....

Date..... Date.....



## **9.0 APPENDIX 2: Postnatal Depression Project Inclusion & Exclusion Criteria**

**FREMANTLE HOSPITAL AND HEALTH SERVICE  
DIRECTORATES OF MENTAL HEALTH  
AND  
COMMUNITY & WOMEN'S HEALTH**

**POSTNATAL DEPRESSION PROJECT**

**INCLUSION AND EXCLUSION CRITERIA**

**Inclusion Criteria:**

Women will be asked to participate in the study if they:

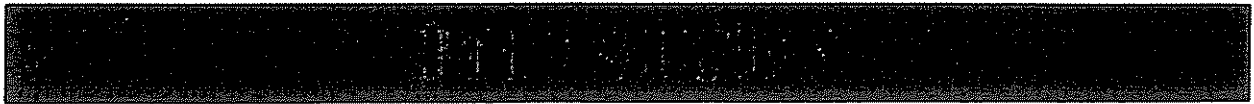
1. Attend the Child Health Clinic for 6-8 week or 7-9 month assessment.
2. Score greater than 9 on the EPDS.
3. Agree to participate in the study.
4. Speak English well enough to be interviewed and complete the survey (to avoid the use of interpreters).

**Exclusion Criteria:**

Women will be excluded from participating in the study if they:

1. Do not consent to participate in the study.
2. Are non-English speaking.
3. Score 1 or more on Item 10 of the EPDS (self harm/suicide).
4. If the client is deemed as a risk to others (including infant).
5. Under 18 years of age.

**10.0 APPENDIX 3:**  
**Postnatal Depression Scale Demographic Questionnaire**  
**Edinburgh Postnatal Depression Scale**  
**Quality of Life Index (Ferrans & Powers, 1985)**



**PART 1: DEMOGRAPHIC INFORMATION**

*Screening Visit*

CODE: .....

OFFICE USE									
0	1	2	3	4	5	6	7	8	9
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please use a ball point pen to complete this form. All questions simply require you to colour in the circle that you feel is the most appropriate answer or write the answer in the space provided.

1.1 Age: ..... years

OFFICE USE									
0	1	2	3	4	5	6	7	8	9
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

1.2 Marital Status:

- Married
- Single
- Divorced
- Defacto Relationship

1.3 If you are in a relationship, please indicate on a scale of 1- 5 how you would rate your level of satisfaction regarding your relationship with your partner:

- Very Unsatisfied 1
- 2
- 3
- 4
- Very Satisfied 5

1.4 Please indicate your ethnicity:

- Born in Australia
- Born Overseas
- Aboriginal or Torres Strait Islander

1.5 Please indicate your partner's ethnicity:

- Born in Australia
- Born Overseas
- Aboriginal or Torres Strait
- Islander

1.6 What is your current employment status?

- Home duties
- Employed outside of home
- Employed from home

1.7 What is your main support network at this point in time?

- Husband/Partner
- Family
- (eg. Parents, siblings)
- Friends
- Health Professionals
- (eg. GP, Child Health Nurse, Social Worker, etc.)

1.8 Have you ever been diagnosed with mental illness (eg. anxiety)?

- Yes
- No

1.9 Are you currently on any medication?

- Yes
- No

1.10 If you answered 'Yes' to Question 1.9, please give the name(s), dose(s) and reason for taking the medication.

<i>Name of medication</i>	<i>Dose</i>	<i>Reason for taking medication</i>
.....		
.....		
.....		
.....		



1.11 Age of Infant: ..... weeks

OFFICE USE									
0	1	2	3	4	5	6	7	8	9
0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0

1.12 How many children have you given birth to? .....

0	1	2	3	4	5	6	7	8	9
0	0	0	0	0	0	0	0	0	0

1.13 EPDS Score: .....

0	1	2	3	4	5	6	7	8	9
0	0	0	0	0	0	0	0	0	0

**EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)**

J L Cox, J M Holden, R Sagovsky (1987)

Name:

Address:

Baby's Age:

As you have recently had a baby we would like to know how you are feeling. Please UNDERLINE the answer which 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 always 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, not at all

**10. The thought of harming myself has occurred to me.**

Yes, quite often

Sometimes

Hardly ever

Never

## QUALITY OF LIFE INDEX

Ferrans, C. & Powers, M. (1984) Permission to use index obtained from authors  
1999  
email: cferrans@uic.edu

**Instructions:** Please use a dark ball point pen to complete this form. All questions simply require you to fill in the circle that you feel is the most appropriate answer. Please give your own responses without conferring with anyone else. Answer all of the questions. When you have completed the survey, please hand it to the child health nurse.

Code:.....

### Office Use Only

0	1	2	3	4	5	6	7	8	9
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### Part 1: QUALITY OF LIFE INDEX A

For each of the following statements, please choose the answer that best describes HOW SATISFIED you are with that area of your life. Using a dark ball point pen please mark your answer by filling in the circle for the number that is the most appropriate answer. There are no right or wrong answers. 1= Very Dissatisfied; 2= Moderately Dissatisfied; 3= Slightly Dissatisfied; 4= Slightly Satisfied; 5= Moderately Satisfied; 6= Very Satisfied.

How satisfied are you with:	Very Dissatisfied					Very Satisfied
	1	2	3	4	5	6
1. Your health?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Your health care?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. The amount of pain that you have?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. The amount of energy you have for everyday activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Your ability to take care of yourself without help?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. The amount of control you have over your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Your chances of living as long as you would like?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Your family's health?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Your children?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Your family's happiness?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Your sex life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



How satisfied are you with:	Very Dissatisfied				Very Satisfied	
	1	2	3	4	5	6
12. Your spouse, lover or partner?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Your friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. The emotional support you get from your family?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. The emotional support you get from people other than your family?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Your ability to take care of family responsibilities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. How useful you are to others?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. The amount of worries in your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Your neighbourhood?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Your home, apartment, or place where you live?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. Your job (if employed)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22. Not having a job (if unemployed, retired, or disabled)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23. Your education?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24. How well you can take care of your financial needs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25. The things you do for fun?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26. Your chances for a happy future?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
27. Your peace of mind?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
28. Your faith in God?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
29. Your achievement of personal goals?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
30. Your happiness in general?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
31. Your life in general?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
32. Your personal appearance?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
33. Your self in general?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## Part 2: QUALITY OF LIFE INDEX B

For each of the following statements, please choose the answer that best describes **HOW IMPORTANT** that area of your life is to you. Using a dark ball point pen please mark your answer by **filling in the circle** for the number that is the most appropriate answer. There are no right or wrong answers. 1= Very Unimportant; 2= Moderately Unimportant; 3 =Slightly Unimportant; 4= Slightly Important; 5= Moderately Important; 6= Very Important

How important to you is:	Very Unimportant					Very Important
	1	2	3	4	5	6
1. Your health?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Your health care?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Having no pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Having enough energy for everyday activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Taking care of yourself without help?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Having control over your life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Living as long as you would like?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Your family's health?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Your children?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Your family's happiness?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Your sex life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Your spouse, lover or partner?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Your friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. The emotional support you get from your family?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. The emotional support you get from people other than your family?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Taking care of family responsibilities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Being useful to others?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Having no worries?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

19. Your neighbourhood?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	<b>Very Unimportant</b>					<b>Very Important</b>	
<b>How important to you is:</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	
20. Your home, apartment or place where you live?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
21. Your job (if employed)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
22. Having a job (if unemployed, retired or disabled)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
23. Your education?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
24. Being able to take care of your financial needs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
25. Doing things for fun?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
26. Having a happy future?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
27. Your peace of mind?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
28. Your faith in God?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
29. Achieving your personal goals?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
30. Your happiness in general?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
31. Being satisfied with life?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
32. Your personal appearance?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
33. Yourself in general?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

**You have now completed the Quality of Life Index.  
Thank you for your participation.**

## **11.0 APPENDIX 4: Composite International Diagnostic Interview**



WORLD HEALTH ORGANIZATION  
ORGANISATION MONDIALE DE LA SANTE

DISTR. : LIMITED  
DISTR. : LIMITEE  
MNH/NAT/89.5, Rev. 3  
ORIGINAL: ENGLISH

COMPOSITE INTERNATIONAL DIAGNOSTIC INTERVIEW (CIDI)

(AUTHORIZED CORE VERSION 1.0 - DECEMBER 1989)

-----  
 SECTION E: DEPRESSION: E1-E49  
 -----

NOTE: FOR EACH SYMPTOM CODED FRB5 IN SECTION E, PLEASE ASK (OR CODE IF ALREADY KNOWN OR VOLUNTEERED BY SUBJECT), "IN THE LAST 4 WEEKS (REPEAT UNDERLINED PART OF QUESTION)" AND CIRCLE THE ADDITIONAL 6 CODE IF YES.

E1 In your lifetime, have you ever had two weeks or more when nearly everyday you felt sad, blue, depressed? FRB: 1 5 6

E2 Have you ever had two years or more in your life when you felt depressed or sad most days, even if you felt OK sometimes? NO..(SKIP TO E7).....1 YES.(ASK A BEFORE PROBING).5  
 A. Did a period like that ever last 2 years without being interrupted by your feeling OK for 2 months? FRB: 1 2 5

IF NOT CODED FRB 5 SKIP TO E7

ONS/REC: When did your (first/last) period of at least two years of feeling sad most of the time begin/end? ONS: 1 2 3 4 5 6 AGE ONS: / / REC: 1 2 3 4 5 6 AGE REC: / /

-----  
 E3 During this period were you often in tears? NO.....1 YES.....5

-----  
 E4 Did you frequently feel hopeless during this period? NO.....1 YES.....5

-----  
 E5 During this period of two years or more did you often feel that you could not cope with your everyday life and responsibilities? NO.....1 YES.....5

-----  
 E6 During this period did you feel that your life had always been bad and wasn't going to get any better? NO.....1 YES.....5  
 -----

INT:ASK E7-E31. OMIT WORDS IN [], CODE IN COLUMN I

FOR EACH QUESTION IN E7 TO E31 CODED 5, ASK (OR CODE IF ALREADY KNOWN) WHETHER THE SYMPTUM HAD OCCURRED IN THE LAST 4 WEEKS. IF YES CODE 6.

FOR QUESTIONS DEALING WITH A TWO-WEEK PERIOD IT IS NOT NECESSARY THAT SX BE PRESENT FOR TWO WEEKS OR MORE IN THE LAST 4 WEEKS.

		I EVER IN LIFETIME					II [WORST] [PERIOD] NO YES	
APPETITE								
E7	Has there ever been a period of two weeks or longer when you <u>lost</u> [Did you lose] <u>your appetite</u> ? CAN BE POSITIVE EVEN IF FOOD INTAKE IS NORMAL.	PRB: 1	3	4	5*	6	1	5
MD: ..... OTHER: .....								
IF NOT CODED PRB 5, SKIP TO E8								
A. During (this/any) of these episode(s) did you lose your appetite completely?		NO.....1				1	5	
		YES.....5				6		
E8	Have you ever <u>lost</u> [Did you lose] <u>weight without trying</u> to ..as much as two pounds/a kilo a week for several weeks [or as much as (10 lbs/4.5 kg) altogether]?	PRB: 1	3	4	5*	6	1	5
MD: ..... OTHER: .....								
IF NOT CODED 5, SKIP TO E9								
A. During (this/any of these) periods how much weight did you lose?		LB	/	/		LB	/	/
		KG	/	/		KG	/	/
E9	Has there ever been at least 2 weeks when you had [Did you have] an <u>increase in appetite</u> , other than when you were growing (or pregnant)?	PRB: 1	3	4	5*	6	1	5
MD: ..... OTHER: .....								
E10	Have you ever had a period when your eating increased so much [Did your eating increase so much] that you <u>gained as much as two pounds a week for several weeks</u> (or (10 lbs/4.5 kg) altogether)? CODE 1 IF REBOUND AFTER MALNUTRITION.	PRB: 1	3	4	5*	6	1	5
MD: ..... OTHER: .....								
IF NOT CODED PRB 5, SKIP TO E11								
A. What is the most you ever gained in (one of (these/this) period(s)?		LB	/	/		LB	/	/
		KG	/	/		KG	/	/

SLEEP

EVER

[WORST]  
NO YES

E11 Have you ever had two weeks or more when nearly every night you had [Did you have] trouble falling asleep?

PRB: 1 3 4 5\* 6 1 5

MD: ..... OTHER: .....

IF NOT CODED '5' SKIP TO E 12

A. Have you ever had 2 weeks or more, when nearly every night it took you [Did it take you] at least two hours to fall asleep?

NO...1 6 1 5  
YES...5

E12 Have you ever had two weeks or more when nearly every night you had [did you have] trouble staying asleep?

PRB: 1 3 4 5\* 6 1 5

MD: ..... OTHER: .....

IF NOT CODED '5' SKIP TO E13

A. Did you ever have a period of two weeks or more, when nearly every night you lay [Did you lie] awake more than one hour?

NO...1 6 1 5  
YES...5

E13 Have you ever had two weeks or more when nearly every night you had [Did you have] trouble with waking up too early?

PRB: 1 3 4 5\* 6 1 5

MD: ..... OTHER: .....

IF NOT CODED '5' SKIP TO E14

A. Have you ever had a period of two weeks or more when nearly every morning you would [Did you] wake up at least two hours before you wanted to?

NO....1 6 1 5  
YES...5

E14 Have you ever had two weeks or longer when nearly every day your were [Were you] sleeping too much?

PRB: 1 3 4 5\* 6 1 5

MD: ..... OTHER: .....



TIRE

EVER

[WORST]  
NO YES

E15 Has there ever been a period lasting 2 weeks or more when you lacked energy or felt [Did you feel] tired out all the time even when you had not been working very hard? PRB: 1 3 4 | 5\* | 6 1 5

MD: ..... OTHER: .....

IF NOT CODED '5' SKIP TO E16

A. Have you ever been [Were you] completely without energy for two weeks or more? NO.....1 YES.....5 | 6 1 5

E16 Did you ever have two weeks or more when you felt [Did you feel] very bad when you got up, but felt better later in the day? PRB: 1 3 4 | 5\* | 6 1 5

MD: ..... OTHER: .....

SLOW/RESTLESS

E17 Has there ever been two weeks or more when nearly everyday you talked or moved [Did you talk or move] more slowly than is normal for you? PRB: 1 3 4 | 5\* | 6 1 5

MD: ..... OTHER: .....

IF NOT CODED PRB 5, SKIP TO E18

A. During this (one of these) period(s) did [Did] any one else notice that you were talking or moving slowly? NO.....1 YES.....5 | 6 1 5

E18 Has there ever been two weeks or more when nearly everyday you had [Did you have] to be moving all the time - that is you couldn't sit still and paced up and down? PRB: 1 3 4 | 5\* | 6 1 5

MD: ..... OTHER: .....

-----  
 LOST INTEREST

EVER

[WORST]  
 NO YES

E19 Has there ever been a period of several weeks  
 when your interest in sex was [Was your interest  
 in sex] a lot less than usual?

PRB: 1 2 3 4 | 5\* 6 1 5

MD: ..... OTHER: .....

IF NO INTEREST EVER, CODE PRB 2 AND SKIP TO E20  
 IF NOT CODED 5, SKIP TO E20

A. Did you ever [Did you] completely lose  
 your interest in sex?

NO.....1  
 YES.....5 | 6 1 5

-----  
 E20 Has there ever been 2 weeks or longer when you  
lost [Did you lose] interest in most things  
 like work or hobbies or things you usually liked  
 to do for fun?

PRB: 1 3 4 | 5\* 6 1 5

MD: \_\_\_\_\_ OTHER: \_\_\_\_\_

IF NOT CODED 5, SKIP TO E21

A. Did you ever [Did you] completely lose all  
interest in things like work or hobbies or  
 things you usually liked to do for fun?

NO.....1  
 YES.....5 | 6 1 5

-----  
 E21 Have you ever had 2 weeks or longer when  
 you lost [Did you lose] the ability to  
enjoy having good things happen to you,  
 like winning something or being praised  
 or complimented?

NO.....1  
 YES.....5 | 6 1 5

WORTHLESS		EVER		[WORST]		
				NO	YES	
E22	Has there ever been two weeks or more when nearly every day you <u>felt</u> (Did you feel):	NO	YES			
	1) <u>worthless</u>	1	5*	6	1	5
	2) <u>sinful</u>	1	5*	6	1	5
	3) <u>guilty</u>	1	5*	6	1	5
IF ANY 5 ASK: Was there a particular reason for feeling (worthless/sinful/guilty)? RECORD EXAMPLE!						
_____						
IF WORTHLESS CODED '1', SKIP TO E23						
A. Did you ever (Did you) feel completely worthless for a week or more?		NO.....1				
		YES.....5		6	1	5
E23	Have there ever been two weeks or more when you <u>felt</u> (Did you feel) that you were <u>not as good as other people</u> or inferior?	FRB: 1	5*	6	1	5
E24	Has there ever been a period of two weeks or more when you had (Did you have) so <u>little self-confidence</u> that you wouldn't try to have your say about anything?	FRB: 1	5*	6	1	5
IF NOT CODED 5, SKIP TO E25						
A. Did you ever have a period of 2 weeks or more when you entirely <u>lost</u> (Did you entirely lose) <u>your self-confidence</u> ?		NO.....1				
		YES.....5		6	1	5

-----  
**TROUBLE THINKING**

EVER

[WORST]  
 NO YES

-----  
 E25 Has there ever been two weeks or more when  
 nearly every day you had [Did you have] a  
 lot more trouble concentrating than is  
 normal for you? PRB: 1 3 4 | 5\* 6 1 5

MD: ..... OTHER: .....

A. Has there ever been a period of two weeks  
 or more when you were unable [Were you  
 unable] to read things that usually interest  
you or watch television or movies you usually  
 like, because you couldn't pay attention to them?  
 NO.....1 1 5  
 YES.....5 6

-----  
 E26 Have you ever had two weeks or more when  
 nearly every day your thoughts came [Did  
 your thoughts come] much slower than  
usual or seemed mixed up? PRB: 1 3 4 | 5\* 6 1 5

MD: ..... OTHER: .....

-----  
 E27 Have you ever had two weeks or more when  
 nearly every day you were [Were you] unable to  
make up your mind about things you ordinarily  
 have no trouble deciding about? PRB: 1 3 4 | 5\* 6 1 5

MD: ..... OTHER: .....

IF NOT CODED 5, SKIP TO E28

A. Has there ever been a period (2 weeks or  
 more) when you were [Were you] completely  
unable to make up your mind about things you  
 ordinarily have no trouble deciding about?  
 NO.....1 1 5  
 YES.....5 6

-----

THOUGHTS OF DEATH

EVER

[WORST]  
NO YES

E28	Has there ever been a period of two weeks or more when you <u>thought</u> [Did you think] <u>a lot about death</u> - either your own, someone else's, or death in general?	FRB: 1	5*	6	1	5
E29	Has there ever been a period of two weeks or more when you <u>felt</u> [Did you feel] <u>like you wanted to die</u> ?	FRB: 1	5*	6	1	5
E30	Have you ever felt [Did you feel] so low <u>you thought about committing suicide</u> ?	FRB: 1	5*	6	1	5
E31	Have you ever <u>attempted</u> [Did you attempt] <u>suicide</u> ?	FRB: 1	5*	6	1	5

E32	INT: HAS FRB 5* OR 6 BEEN CODED IN 3 OR MORE BOXES SINCE E7?	NO...(SKIP TO I1)....1
		YES .....5
A.	ENTER NUMBER OF 6's	ENTER # /_

E33	IS E1 (SAD OR DEPRESSED) OR E20 (LOSS OF INTEREST) CODED FRB 5?	NO...(SKIP TO E36)....1
		YES.....5

E34 You said you've had a period of feeling (depressed or uninterested/OWN EQUIVALENT) and also said you've had some other problems like (LIST FRB 5\*s IN E7-E31).

Has there ever been a time when the feeling of (depression/OWN EQUIVALENT) and some of these other problems occurred together -- that is, within the same month?

NO.....(ASK A)....1  
YES.(SKIP TO E35)....5

A. So there's never been a period when you felt (depressed/OWN EQUIVALENT) at the time you were having some of these other problems?

NEVER BEEN A PERIOD...  
(SKIP TO I1).....1  
HAS BEEN A PERIOD ...5

E35 QNS/REC: When was the (first/last) time you had a period of two weeks or more when you had some of these problems and also felt ..(depressed/OWN EQUIVALENT)?

QNS: 1 2 3 4 5 6  
AGE QNS: /\_

REC: 1 2 3 4 5 6  
AGE REC: /\_

SKIP TO E38

E36 You said you have had periods when you ....  
 (LIST PRB 5\*s IN E7-E31). Was there ever  
 a time when several of these problems occurred  
 together -- that is, within the same month? NO. (SKIP TO I1).....1  
 YES.....5

A. When you were having some of these problems,  
 at about the same time were you feeling okay  
 or were you feeling low, gloomy, blue, or  
 uninterested in everything? OKAY. (SKIP TO I1)....1  
 GLOOMY, LOW, ETC.....5

E37 QNS/REC: When was the (first/last) time you  
 had a period of two weeks or more when you  
 had several of these problems and also felt  
 low, gloomy or uninterested in everything? QNS: 1 2 3 4 5 6  
 AGE QNS: \_\_\_\_\_/\_\_\_\_\_  
 REC: 1 2 3 4 5 6  
 AGE REC: \_\_\_\_\_/\_\_\_\_\_

A. Have you ever had periods lasting at least a day but  
 shorter than two weeks when you felt sad, blue,  
 or depressed? NO.. (SKIP TO E38)....1  
 YES.....5

B. Did such a period occur once or twice a month, nearly  
 every month, during the past year? NO.....1  
 DURING SOME MONTHS,  
 BUT NOT EVERY MONTH..2  
 YES.....5

C. Have you ever told a doctor about these shorter spells of  
 depression? NO.....1  
 YES.....5

D. Have these shorter spells of depression interfered with your  
 life or activities a lot? NO.....1  
 YES.....5

E38 What's the longest spell you've ever had when  
 you felt depressed/(OWN EQUIVALENT) and had several  
 of these other problems at the same time? IF  
 WHOLE LIFE OR MORE THAN 19 YEARS, ENTER 996. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 YEARS X 52 = # WEEKS, MONTHS X 4 = # WEEKS # WEEKS

IF 1 TO 13 DAYS, CODE 001, AND SKIP TO ALCOHOL MODULE  
 IF LESS THAN 24 WEEKS, SKIP TO E41  
 IF 24 WEEKS TO 104 WEEKS SKIP TO E40  
 IF MORE THAN 2 YEARS: ASK E39 QNS/REC

E39 QNS/REC: When did you (first/last) have 2 years  
 or more when you felt (blue/OWN EQUIVALENT)  
 and had several these other problems at the  
 same time? QNS: 1 2 3 4 5 6  
 AGE QNS: \_\_\_\_\_/\_\_\_\_\_  
 REC: 1 2 3 4 5 6  
 AGE REC: \_\_\_\_\_/\_\_\_\_\_

E40 INT. IF CA3 WAS CODED 6 (PERSISTENT WORRY ABOUT SEVERAL THINGS), ASK E40; OTHERS SKIP TO E41

You said earlier that you had a long period when you were anxious and worrying about several different things. Did this whole spell of feeling anxious and worried fall within a period when you were depressed?

NO.....1  
YES.....5

E41 Now I'd like to ask about spells when you felt both (depressed/OWN EQUIVALENT) and had some of these other problems like (LIST ANY ITEM CODED PRB 5\* FROM 2 OR 3 BOXES CONTAINING E7-E31). In your lifetime, how many spells like that have you had that lasted two weeks or more? IF 96 SPELLS OR MORE, ENTER 96.

\_\_\_\_\_  
# SPELLS

IF ONLY ONE SPELL, SKIP TO E42

A. Between (any of) these spells were you feeling OK at least for some months?

NO.(SKIP TO E42)....1  
OKAY.....5

B. Between (any of) these spells were you fully able to work and enjoy being with other people?

NO.(SKIP TO E42)....1  
YES.....5

C. Did that "normal" period last at least 6 months?

NO.....1  
YES.(SKIP TO E42)....5

D. Did it last at least 2 months?

NO.....1  
YES.....5

E42 Were you ever in a hospital (overnight or in a day hospital) because of any spell(s) of feeling depressed?

NO.....1  
YES..(SKIP TO E44)...5

E43 Did you tell a doctor about (that/any of those spells)?

NO.....1  
YES..(SKIP TO 2)....5

1. Did you tell any other professional about it/any of them?

NO.....1  
YES.....5

2. Did you take medication more than once because of (that spell/any of those spells)?

NO.....1  
YES.....5

3. Did (that spell/any of those spells) interfere with your life, work, or activities a lot?

NO.....1  
YES.....5

4. Was any spell so bad that it kept you from working or from seeing friends or relatives?

NO.....1  
YES.....5

-----  
E44 Did (this spell/any of those spells) occur just after someone close to you died? NO...(SKIP TO E45)...1  
YES..... 5

IF VOLUNTEERS BEGAN MORE THAN 2 MONTHS AFTER DEATH, CODE 1 AND SKIP TO E45.

A. Have you had any spell of (depression/OWN EQUIVALENT) along with these other problems like (LIST 3 SX CODED 5\* FROM E7-E31) at times when it wasn't just after a death? NO, ONLY AFTER DEATH...  
SKIP TO E45.....1  
YES, OTHER TIMES .....5

B. IF SPELL IN LAST YEAR (E35 = 1-5 OR E37 REC = 1-5, ASK) What about the spell or spells you had in the last year? Was that due to someone close to you dying? YES, ONLY DUE TO DEATH ....2  
NO, NOT ONLY DUE TO DEATH..5

IF ONLY ONE SPELL CODED IN E41 AND THAT SPELL IS CURRENT (E35REC OR E36REC WITHIN LAST 4 WEEKS) SKIP TO ALCOHOL MODULE.

-----  
E45 INT: IS MORE THAN ONE SPELL CODED IN E41? NO.....1  
YES...(SKIP TO E47)..5

-----  
E46 INT: IS LONGEST SPELL LONGER THAN 52 WEEKS (E38)? NO.(SKIP TO E48).....1  
YES .....5

-----  
E47 Now I'd like to know about the time when you were feeling (depressed/OWN EQUIVALENT) for at least two weeks and had the largest number of these other problems at the same time. How old were you at that time? (IF CAN'T CHOOSE: Then pick one bad spell). \_\_\_\_\_  
AGE

IF WORST EPISODE IS CURRENT, SKIP TO E49.

-----  
E48 I'd like to know which of these other problems you had during(this/that) spell of (depression/OWN EQUIVALENT). For instance, during (this/that) spell (when you were \_\_\_/\_\_\_ years old) (RETURN TO E7; BEGINNING WITH WORDS IN []), READ EACH QUESTION CODED PRB 5 IN E7-E31)

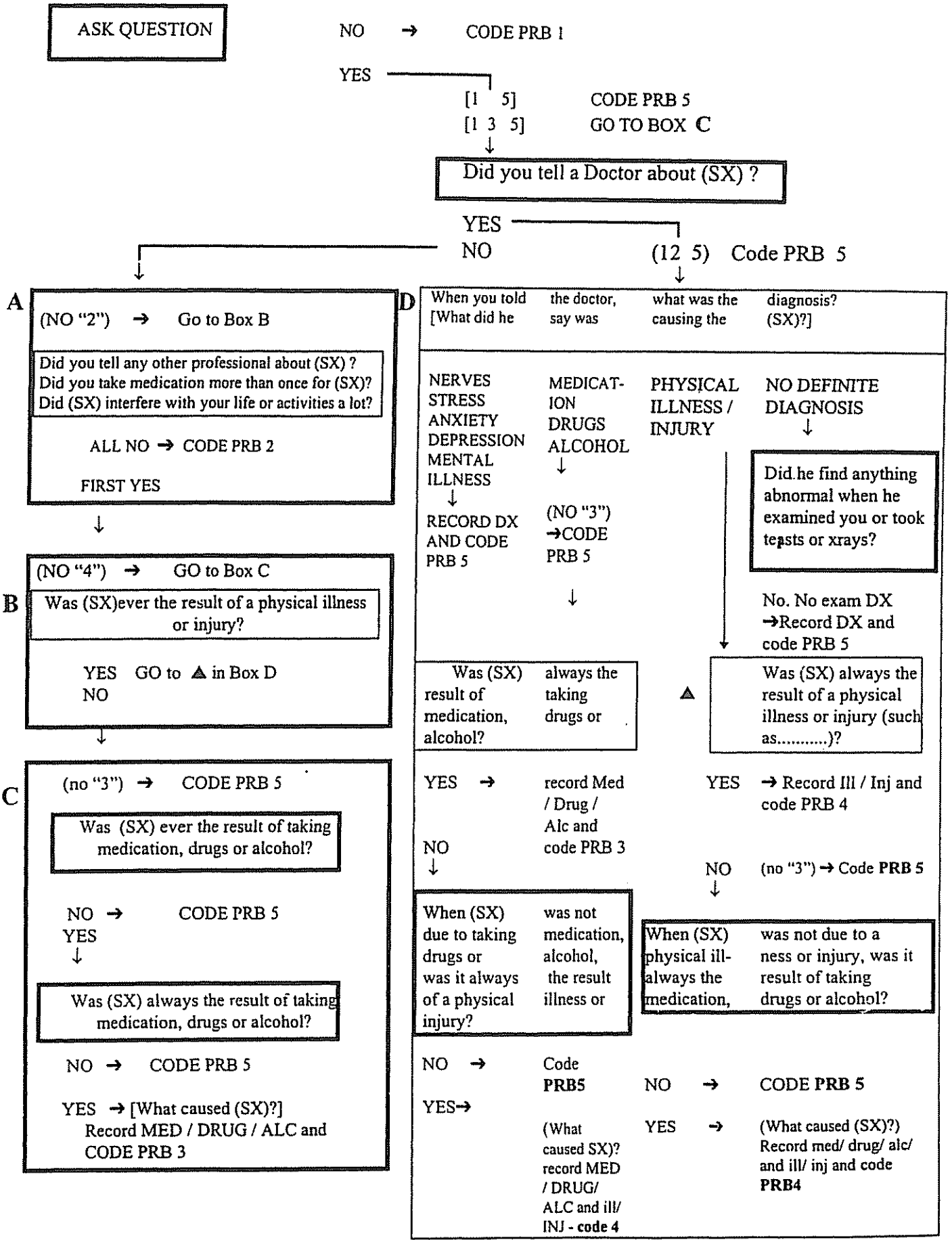
IF OCCURRED DURING THIS SPELL OF DEPRESSION, CODE 5 IN COL. II.  
IF DID NOT OCCUR THEN CODE 1 IN COL. II.

-----  
IF MORE THAN ONE EPISODE, ASK E49, OTHERS TO GO ALCOHOL MODULE

E49 You told me you had more than one episode where you felt (depressed/OWN EQUIVALENT). During any of/your other episodes, did you have as many of these other problems as you did in the spell you just described (or in the last month if worst spell is current)? NO.....1  
YES, IN AT LEAST  
ONE OTHER.....5



# PROBE FLOW CHART 10/88



ASK QUESTION

NO → CODE PRB 1

YES → [1 5] CODE PRB 5  
 [1 3 5] GO TO BOX C

Did you tell a Doctor about (SX) ?

YES → (12 5) Code PRB 5  
 NO →

**A** (NO "2") → Go to Box B

Did you tell any other professional about (SX) ?  
 Did you take medication more than once for (SX) ?  
 Did (SX) interfere with your life or activities a lot?

ALL NO → CODE PRB 2  
 FIRST YES →

**B** (NO "4") → GO to Box C

Was (SX) ever the result of a physical illness or injury?

YES GO to ▲ in Box D  
 NO →

**C** (no "3") → CODE PRB 5

Was (SX) ever the result of taking medication, drugs or alcohol?

NO → CODE PRB 5  
 YES ↓

Was (SX) always the result of taking medication, drugs or alcohol?

NO → CODE PRB 5  
 YES → [What caused (SX)?]  
 Record MED / DRUG / ALC and CODE PRB 3

When you told the doctor, what was the diagnosis? [What did he say was causing the (SX)?]	NERVES STRESS ANXIETY DEPRESSION MENTAL ILLNESS	MEDICATION DRUGS ALCOHOL	PHYSICAL ILLNESS / INJURY
	↓ RECORD DX AND CODE PRB 5	↓ (NO "3") → CODE PRB 5	↓ NO DEFINITE DIAGNOSIS ↓ Did he find anything abnormal when he examined you or took tests or xrays? No. No exam DX → Record DX and code PRB 5
	Was (SX) result of medication, alcohol?	Was (SX) always the taking drugs or alcohol?	▲ Was (SX) always the result of a physical illness or injury (such as.....)?
YES →	record Med / Drug / Alc and code PRB 3	YES → Record Ill / Inj and code PRB 4	
NO ↓		NO (no "3") → Code PRB 5	
When (SX) due to taking drugs or was it always of a physical injury?	was not medication, alcohol, the result illness or injury?	When (SX) physical illness or injury, was it always the result of taking medication, drugs or alcohol?	
NO → Code PRB 5	Code PRB 5	NO → CODE PRB 5	
YES → (What caused SX)? record MED / DRUG / ALC and ill/ INJ - code 4		YES → (What caused (SX)?) Record med/ drug/ alc/ and ill/ inj and code PRB 4	

Other professional includes psychologists, social workers, counsellors, nurses, dentists, shiropractors, healers and podiatrists.

Doctor includes psychiatrist, other medical doctors, osteopaths and students in training to be medical doctors or osteopaths

**ONS / REC QUESTIONS**

A. When was the( first / last) time you had (SX)?

**ONS / REC CODES**

1. w/in last 2 weeks
2. 2 wks to < 1 mo ago
3. 1 mo to < 6 mo ago
4. 6 mo to less than 1 year ago
5. In the last twelve months, DX when
6. More than 1 year ago. ASK ONS / REC AGE: How old were you the (first / last) time you had (SX)?

< = less than

## **12.0 APPENDIX 5: Two half-day program for workshop**

**FREMANTLE HOSPITAL AND HEALTH SERVICE  
DIRECTORATES OF MENTAL HEALTH AND  
COMMUNITY AND WOMEN'S HEALTH**

**POSTNATAL DEPRESSION WORKSHOP**



Prepared by:

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School of Nursing, Curtin University of Technology

Clinical Nurse Consultant, Directorate of Mental Health

Fremantle Hospital and Health Service

24th & 31st July, 2000

## PREAMBLE

Welcome to the workshop designed to familiarise you with the postnatal depression project. This collaborative venture by the Directorates of Mental Health and Community and Women's Health aims to increase child health nurses' level of knowledge and skills to work with families who have a member experiencing child birth stress or postnatal depression.

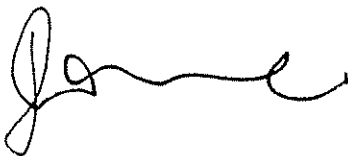
This workshop has been developed to allow us to:

1. Become familiar with the project.
2. Develop expertise in the use of the assessment and screening tools that will be used in the project.
3. Obtain education on depression.
4. Develop skills in the areas of cognitive behavioural therapy and *Egan's Skilled Helper Model*, both of which are an integral part of this project.
5. Facilitate the collaborative relationship between the Psychiatric Consultation and Liaison nurse (Christine Axten) and staff at the Directorate of Community and Women's Health.

This is an interactive workshop designed to encourage us all to participate. It will allow staff involved to clearly understand each step of the project and to feel comfortable with the role they have agreed to fulfil. At the end of the workshop you will be asked to complete an evaluation to determine if you perceive that you are now confident to participate in the study.

After the workshop if you have any questions please contact me on 92662062 or on email at [downiej@nursing.curtin.edu.au](mailto:downiej@nursing.curtin.edu.au) or [jill.downie@health.wa.gov.au](mailto:jill.downie@health.wa.gov.au)

*Thank you for attending and I trust the workshop will be an enjoyable learning experience for all of us*



Jill Downie RN, RM, PhD  
Principal Researcher  
July 2000

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## **INTRODUCTION**

The workshop will focus on four major areas:

1. Education on depression, including postnatal depression;
2. Overview of the project including the assessment and intervention tools to be used;
3. Enhancing communication skills through the use of *Egan's Skilled Helper Model*, and
4. Cognitive behaviour techniques.

## **DEPRESSION**

### **Facts:**

1. Clinical depression is often referred to as the common cold of psychiatry.
2. 25% of women and 12.5% of men will have a major depression in their lifetime.
3. At any given time it is estimated that approximately 15-20% of adults suffer significant levels of depressive symptomatology. At least 12% experience depression severe enough to require professional intervention to alleviate the symptoms
4. The important issue is the quality of life and the quantity of depressive symptoms people suffer over time. (Hawton, Salkovskis, Kirk & Clarke (1989).
5. The rate of depression among women is approximately twice the rate of men (Johnson, 1997).
6. Depression and bi-polar disorders are disturbances in mood.
7. Depression may occur at any age and seems unrelated to the pressures of modern society. These disorders have been present since ancient times.
8. Depressive symptoms may differ across the life span.

### **What is postnatal depression?**

A major or uni-polar depression in the postnatal period.

The depression is repetitive, and is particularly destructive to family relationships, and has a great impact on children in terms of learning difficulties, affective illness and behavioural problems.

Genetic transmission is possible and environmental factors may increase genetic vulnerability. Severe depression during this period requires clinical treatment and nurses are in a key position to help families develop improved coping skills and family relationships (Johnson, 1997).

About 40% of women will report some emotional disturbance or cognitive dysfunction in the postnatal period. The *postnatal blues* has been described by many mothers and these have been ascribed to the rapid change in hormonal levels, stress as well as the increased responsibility of motherhood.

### **What is a postpartum psychosis?**

Postpartum psychosis is a clinical syndrome that occurs after childbirth and is characterised by delusions. Thoughts of harm towards self or baby are a threat. This risk increases if there is a history of mood disorders in the family. The psychosis occurs around the third day postpartum. A few cases have resulted from some of the drugs used in peri-natal period eg. scopolamine, toxæmia, or a sudden fall of oestrogen and progesterone levels immediately following pregnancy. Occurs in about 1 to 2 per 1,000 deliveries.

### **Aetiology of depression:**

While it seems likely that no single factor can explain depression, generally the onset and course can be seen to relate to a variety of biological, historical, environmental and psychosocial variables. These include:

Genetic influences: Occurs in families. Chromosome 11 and 18 (bi-polar disorder) have been implicated in depression.

Disturbances in neurotransmitter functioning:

Various neurotransmitters are implicated in depression, for example:

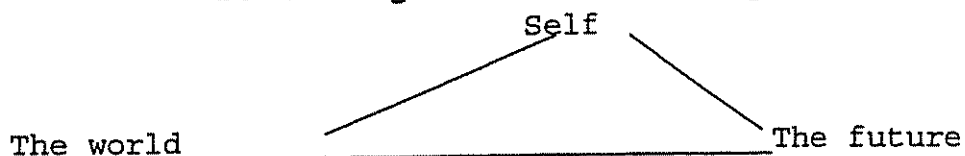


- *Amines Monoamines*: Norepinephrine (NE) (Implicated in anxiety and mood disorders. Antidepressants block the re-uptake of NE into the presynaptic cell or inhibit monoamine oxidase from metabolising it.
- Serotonin (5-HT) Role in arousal and wakefulness, particularly the onset of sleep. Plays a role in mood, probably in delusions, hallucinations and withdrawal seen in schizophrenia. Plays a role in anxiety and affective disorders. Antidepressants block its uptake into the presynaptic cell.
- *Peptides*: Chains of amino acids found throughout the body. Role as neurotransmitters in the CNS is still relatively unknown

Psychosocial and environmental influences:

- Interpersonal theory: beginning in childhood from real or perceived loss.
- Psychoanalytic theory: Unexpressed anger is turned in on oneself.
- Cognitive theory: Normal responses are mediated by cognitive processes that allow us to accurately interpret reality. In psychopathology, eg depression, this ability is impaired and errors are made. Beck calls the normal interpretation of reality the *schemas* and cognitive errors produce negative *schemas* that persist despite contradictory evidence. Hence depressed people ~~with~~ have *schemas* that view the world as either black or white, with little option and with the expectation that people are good or bad. Aaron Beck developed cognitive therapy based on the premise that mood and emotions are determined by thoughts and ideas. Therefore, by altering thoughts and ideas the person's mood and emotions will also be changed.

**Beck's Cognitive Triad of Depression**



The cognitive triad of depression consists of negative view of self. The person sees themselves as defective, inadequate, deprived, worthless and undesirable. They view the world as negative, demanding and self

defeating and therefore they expect failure and punishment. The future holds little relief and they expect hardship, suffering, deprivation and failure.

#### Hormonal:

Hormonal secretion is influenced by neurotransmitter functioning in the limbic system and therefore, neurotransmitter dysfunction will also effect hormone functioning. Postnatal period is another factor massive hormonal changes with lowered oestrogen and prolactin levels.

#### Factors that increase vulnerability include:

- Being a young, single mother in charge of a household living in poverty, being a young adult or being elderly.
- Experiencing a prior loss or trauma, financial problems, social isolation, marital or parental discord.
- Being unemployed outside the home or lacking an intimate relationship.
- Having 3 or more children living at home or caring for an elder in the home.
- Seeking feelings of love, respect, recognition and worth in life through another person or group.

### **TYPES OF DEPRESSION AND BI-POLAR DISORDERS**

All categories may vary in relation to symptoms, severity and persistence.

#### **1. DEPRESSIVE DISORDERS:**

- **Major depressive disorder (uni-polar disorder):** Last for several weeks to months, followed by periods of relatively normal mood. Symptoms include low mood, lack of interest in self, sleep disturbances, appetite lasting for 2/52 weeks.

Average episode last around four months may last up to 12 without remitting. However, many become chronic. Ten to 15% don't get better. Many reasons have been suggested, alcohol, decreased work opportunities, single parent homes, violence.

Major depression occurring after childbirth is called postnatal depression.

Highest in the 18-44 year old age group. May or may not have psychotic features.

Symptoms must be present for most of the day for at least 2 weeks and cause significant distress or impairment of functioning.

Studies suggest that people with this type of depression will have at least one subsequent episode of depression in their lifetime. Have a 50% chance of another episode in 10 years.

- **Dysthymic disorder:** milder form of depression, symptoms not as severe but are persistent. Depressed or irritable mood occurring for most of day, and for more days than not, for at least 2 years.

During this time the client has no more than 2 months when symptoms are not present. Chronic nature is of concern as the client may have a life long struggle with depressive feelings.

Dysthymia may precede a major depression.

- **Depressive disorder not otherwise stated:** Depressive disorders that do not meet the criteria of other depressive disorders. Examples include post psychotic disorder of schizophrenia, premenstrual dysphoric disorder.

#### 1. BIPOLAR DISORDERS (Affective disorders)

One of the largest groups of mental illnesses.

- **Bipolar I:** One or more manic episodes alternating with depression.
- **Bipolar II:** One or more major depressive episodes and at least one hypomanic episode without a history of a true manic episode.
- **Cyclothymic Disorder:** Clients experience repeated non psychotic depression and hypomania for at least 2 years. Diagnosed only if a major depression or manic episodes have not been present.
- **Bipolar disorder not otherwise stated:** Rapid alteration of mood (depression and mania for days) that does not meet the criteria of major depression or manic episode.

**Important:**

**When assessing depressed people the nurse must review what:**

1. Made the client vulnerable?
2. Triggered the disturbance?
3. Made the client's defenses fail?
4. Kinds of intervention will help the client adapt and grow?
5. What is the risk to self and others?



# OUTLINE OF THE POSTNATAL DEPRESSION PROJECT INCLUDING ASSESSMENT AND INTERVENTION TOOLS

## Overview of the postnatal depression project

This project has been designed as a pilot study to evaluate the effectiveness of a collaborative intervention program developed by nurses at the Directorates of Mental Health Services and Community and Women's Health. The project aims to identify and manage childbirth stress and postnatal depression in the community.

## Procedure

- Week 0**      Enrolment into the study (Complete EPDS, demographic profile and Quality of Life Index)
- Week 1**      One week later an appointment at the Child Health Clinic. Complete the Composite Diagnostic Interview for Depression, Postnatal assessment and Management plan. View video.
- Week 2**      Home visit - Journal and Workbook
- Week 3**      Telephone visit - telephone schedule
- Week 4**      Home visit - Journal and Workbook
- Week 5**      Telephone visit - telephone schedule
- Week 6**      Appointment at the Child Health Clinic (Complete the EPDS and Quality of Life Index) Appointments made with client for 6 weeks later for monitoring and then a further 6 weeks for completion of the project documentation.
- Week 12**     Clinic appointment for monitoring of client.
- Week 18**     Clinic appointment for completion of EPDS and Quality of Life Index

Intervention and assessment tools:

1. Edinburgh Post Natal Depression Scale - *Dianne Juliff*
2. Ferrens and Powers' Quality of Life Index - *Jill Downie*
3. Demographic Information sheet - *Jill Downie*
4. Inclusion and exclusion criteria - *Jill Downie*
5. Information Sheet and consent form - *Jill Downie*
6. Postnatal assessment and management plan-*Dianne Wynaden*
7. Composite International Diagnostic Interview for depression - *Christine Axten*
8. Workbook - *Dianne Juliff and Christine Axten*
9. Home visits - *Dianne Juliff*
10. Telephone visiting ( what to say) /alternative home visit (what to say)- *Dianne Juliff*

CLINICAL EXERCISE

(Dianne Wynaden, Libby Fitzpatrick and Christine Axten)

You are a child health nurse working at a clinic in the Fremantle area. Jane who you are seeing for the second time arrives for her six week appointment. She has a six week baby girl and two other children both under five years of age. She walks towards the door of the clinic. You greet her and ask her to come into your office.

Week 0

**Step 1:** During your second interview with Jane you complete the EPDS and find that Jane has scored >12 on the scale. She moved to Western Australia with her husband six months ago and she has not established many friends or supports in Western Australia since her arrival. She tells you that her husband works for a mining company and spends a lot of time away from home. You assessment to see if Jane meets the Inclusion Criteria for the study.

**Step 2:** Jane meets the inclusion criteria for the study so she is given the information sheet and the study is explained to her. She agrees to participate and signs the consent form.

**Step 3:** She completes the Ferrens and Powers' *Quality of Life Index* and a *Demographic Information Sheet*.

**Step 4:** You then randomly select from one of two envelopes to determine whether Jane will be placed in the experimental or control group for the study.

You inform Jane that she is allocated to the experimental group. You phone Joane at Woodside on Ph 93391362 to have the client's name added to the study list.

The second client who consents to join the study will be given the second envelope. On this phone call to Joane inform Joane that this client is the second one to be added for your clinic, Joane will then send out more envelopes for future clients.

**Step 5:** You contact Christine Axten and set up a time for you both to meet with Jane next week. You outline that the appointment next week will take approximately 1.5 hours and try to encourage her to find someone to take care of the children during that time. She states her husband will be home next week on leave so he will be able to care for the children.

**Step 6:** Jane agrees to return at the arranged time next week to meet with you and Christine.

#### Week 1

**Step 7:** Jane arrives at the arranged time next week. Christine and you complete the following with Jane:

- *The postnatal assessment and management plan*
- *Composite International Diagnostic Interview for depression*

Following this you make Jane a drink and ask her to watch the video on postnatal depression. During that time Christine and you develop a management plan for Jane. You then discuss this plan with Jane including:

- *The workbook (including the mood scale). It is important to encourage the client to use this workbook in a positive way. All entries should be written from the framework of a positive construct.*
- *The journal*
- *The sequence of home visiting*
- *Arrange a home visit in one week. You also reinforce with Jane that both the home visits will be audiotaped.*

**Step 8:** Christine Axten meets with the Consultant Psychiatrist to discuss the outcomes of the *Composite International Diagnostic Interview for depression*. The form and their written evaluation



is then sent to Dr Jill Downie at Community and Women's Health for data entry and storage ensuring that confidentiality is not breached during this process.

#### Week 2

**Step 9:** You then engage the first home visit with Jane. During this visit Jane should be encouraged to discuss with you the outcomes of her workbook and reflective journal and any other problems since the last time you saw her. It is important for you to focus on the cognitive style Jane is using and to try to encourage her to restructure her thoughts, feelings and conversation in a more positive way. You then encourage Jane to complete the next stage of the workbook. The home visit is audiotaped. You tell Jane that you will contact her by phone next week (if client does not have a phone a short visit will be made that follows the telephone contact protocol).

#### Week 3

**Step 10** Telephone contact is made with Jane following the outlined protocol. The second home visit is arranged for next week.

#### Week 4

**Step 11:** You now conduct the second home visit. The structure of the second visit follows that of the first and is also audiotaped. During this visit another telephone contact time is made with Jane for next week.

#### Week 5

**Step 12:** You make the second telephone contact once again following the outlined protocol. During the contact you arrange an appointment for Jane at the clinic next week.

#### Week 6

**Step 13:** Jane arrives at the clinic. You ask her to complete the following:

- The *EPDS*
- Ferrrens and Powers' *Quality of Life Index*

**Step 14:** Make two further appointments with Jane, six weeks apart, to visit the clinic. The first at Week 12 will be for monitoring six weeks after the completion of the intervention. The second appointment at Week 18 will be to complete the EPDS and the Quality of Life Index to finalise the study.

**Step 15:** Participation in the experimental group for this study is now completed. From now on you will base your decision for further contact with Jane on your clinical judgement of her condition based on established protocols.

**Step 16:** You now finalise any documentation that you have to complete on Jane.

**Step 17:** You now send all documentation to Dr Jill Downie at Community and Women's Health ensuring that confidentiality is not breached during the process.



## EGAN'S SKILLED HELPER MODEL

### THE THREE DIMENSIONS OF COMMUNICATION SKILLS IN THE HELPING PROCESS

1. **Perceptiveness:** Your communication skills are only as good as the accuracy of the perceptions in which they are based.
  
2. **Know how:** Once you are aware of what kind of response is required, you need to be able to deliver it. If the client is anxious and you can see it do something about it just don't keep the knowledge locked up inside you. The nurse must assess these when talking to the client by:
  - using effective listening skills
  - by creating an environment conducive to communication
  - conveying to the client that her needs are important and the nurse is attuned to them.
  
1. **Assertiveness:** Accurate assessment and know how are useless if you are not assertive and therefore, unable to use them. You may need to challenge a client and if you fail to do this then your effectiveness is reduced.

### Three basic interpersonal styles have been identified

1. Non assertive: letting other control behaviour, not acting in own interest.
2. Aggressive: threatening, blaming, hostile.
3. Assertive: openly expressive, spontaneous and considerate of others.

Clients displaying non assertive or aggressive styles may have developed dysfunctional communication patterns.

## ESTABLISHING A THERAPEUTIC RELATIONSHIP WITH THE CLIENT

Built on accurate assessment, establishing a therapeutic relationship with the client requires the nurse to use:

- specific verbal and non verbal communication techniques;
- attending and listening to the client, and
- intervening appropriately.

Important elements of the therapeutic relationship are:

- a) empathy;
- b) attending;
- c) observing, and
- d) listening.

**Empathy:** involves accurate assessment (perception), message delivery (know-how), and assertiveness (timing and focus). It is made up of focusing on the client's experiences, behaviours and feelings.

**Attending:** being with the client in a physical and psychological presence.

- turning and leaning your body towards the client.
- open and natural position of body.
- maintaining eye contact (culturally determined).
- assessing one's own non verbal behaviour for non therapeutic communication messages.

**Observing:** Necessary to comprehend overall non verbal and verbal messages. Observe the client's non verbal messages through their verbal and non verbal behaviour, physiological reactions, skin colour, and appearance.

**Listening:** Listening and projecting a neutral presence enhances the nurse's ability to assess the client's verbal messages and vocal behaviour. Listening requires concentration that:

- minimises distractions.

- conveys objectivity.
- Is not evaluated in terms of agreeing or disagreeing with the client.
- focuses on the client's behaviour uses feedback objectively.

**The stages of the helping process**

1. The present scenario.
2. The preferred scenario.
3. Getting there.

All stages are outcome producing (action orientated).

**1. THE PRESENT SCENARIO:**

- The story.
- Identifying and challenging blind spots.
- The search for leverage (prioritising problems).

**1. THE PREFERRED SCENARIO:**

- Preferred scenario possibilities.
- Creating viable agendas.
- Choice and commitment.

**1. GETTING THERE**

- Brainstorming strategies for actions.
- Choosing the best strategies.

To help find best fit strategies a number of scales and charts can be used, for example,

**Scales:**

1	2	3	4	5	6	7	8	9	10
0	0	0	0	0	0	0	0	0	0

On a scale of 1-10 with ten being the happiest you have ever been please indicate how you feel today.

**ASSESSING CHOICES:**

<p>IF I CHOOSE THIS ACTION WHAT ARE THE:</p>	<p>1. <u>BENEFITS FOR ME</u></p>	<p>2. <u>BENEFITS FOR OTHERS</u></p>
	<p>3. <u>DISADVANTAGES/ COST TO ME</u></p>	<p>4. <u>DISADVANTAGES/ COST TO OTHERS</u></p>

**CHOOSING OPTIONS:**

There are two roads and the choices you make will determine the road that you take.

Road 1

Road 2

- Turning strategies into a plan

## **EXERCISE 1**

Divide into groups of three

### **Person 1: Nurse:**

You are meeting Jane for the first time. You are assessing her story, and trying to identify her preferred scenario. It is important to identify the blind spots that may prevent her from getting there.

Please concentrate on the following:

- ✓ Getting Jane to tell her story
- ✓ Identifying the preferred scenario
- ✓ Challenging blind spots that may come up
- ✓ Developing a basic management plan

What are the main problems?

What would the client like to change?

What are the precipitants for the problem?

When does the problem occur?

What are the consequences of the problem?

What seems to maintain the behaviour?

What management strategies need to be implemented?

### **Person 2: Jane**

You are 26 years of age and you have a six week old baby and two other children under 5. Your husband of six years works for a mining company and he is away for several months of the year. You have moved to Western Australia recently from Queensland because your husband got a better job and he is now selling mining equipment rather than being underground. This was a relief to you as you had always worried about an accident when he was at work.

You do not make friends easily and have not established any real friends since moving here six months ago. Your marriage is OK but you find it very stressful and lonely when your husband is away from home especially since the birth of your new baby. You have never worked outside of the house since marriage and feel that it is your job to do the work in the house and provide a good family life for your husband and children. Your husband is willing to help when he is home but you do not like this very much as you feel it is your role.



**PERSON 3: OBSERVER**

Please watch the interview process between Jane and the nurse and particularly note the:

Communication techniques used by the nurse  
How well did she allow Jane to tell her story?  
Did she challenge any of Jane's comments?  
How realistic was Jane's preferred scenario?



## COGNITIVE BEHAVIOURAL TECHNIQUES

### Important:

Refer to the best practice information sheet for health professionals given as pre reading for this workshop:

### What is cognitive behavioural therapy:

Cognitive behavioural therapy (CBT) is a self help therapy based on behavioural cognitive perspective. Beck viewed CBT as the key to understanding and solving a psychological disturbance within the scope of the individual's awareness. The goal is to help people unravel their distorted thinking and to normalise rather than pathologise events. It also teaches people alternative, more realistic ways of responding to their experiences. According to Johnson (1997, p250) *Because reality is a product of personal meaning that the individual creates, it is important to teach people to hear themselves.* People will respond better to self generated arguments and counterarguments than from information received from others.

CBT is relatively short, sets the agenda at the beginning, assigns homework and teaches new skills. The therapist must be warm and engaging and be genuine and honest with their client.

CBT based on areas:

1. Eliciting automatic thoughts: Automatic thoughts are cognitions that intervene between external events and the person's emotional reaction to the event.  
*Everybody is going to laugh at me when they see what a bad mother I am.*
2. Testing automatic thoughts: The aim of therapy is to help the client test the validity of the thoughts. The goal is to encourage the client to reject the automatic thought. By looking at the whole situation factors can be eliminated that enable the person to see the error of the thought process *Everybody is going to laugh at me when they see what a bad mother I am.*
3. Identifying maladaptive assumptions: As automatic thoughts continue to be identified patterns usually become apparent, that lead to general assumptions. These assumptions guide the client's life. *If I am a bad mother I am also a bad person.* Such assumptions lead to disappointment and depression.

4. Testing the validity of maladaptive assumptions: As with testing the validity of automatic thoughts testing the validity of maladaptive assumptions is similar. Once again the client is encouraged to look at the overall situation and try to base their interpretation or schema of that in reality.

Cognitive behavioural techniques form the basis of the Postnatal Assessment and Management Plan as well as the Childbirth Stress/Postnatal Depression Workbook.

**We have used the cognitive behavioural approach because it:**

1. Is a self help strategy.
2. Allows the individual to identify traps, patterns and distorted views they may have.
3. Proposes a new way of interacting with the outside world.
4. Alters their perception of self.
5. A time limited action orientated approach.

**The aim of these interventions is to encourage:**

- positive self evaluation.
- self reporting.
- develop new coping strategies.
- enhance decision making skills, and
- assume responsibility for behaviour.

**The Postnatal Assessment and Management Plan will help to:**

1. Formulate the problem, and
2. Identify factors maintaining the problem that can be incorporated into a management plan.

Although most of the assessment takes place during the initial contact with the patient the assessment process is ongoing during each contact with the client.

Clients often present with problems where they are unable to differentiate what is the cause or the main problem. Frequently they have vague symptoms or complaints. The aim of initiating the therapeutic process is to help to clarify and identify the problems and focus on the major issues confronting the client.

**The assessment stage focuses on the process of developing strategies that may facilitate change for the client.**

- During this time it is important that the nurse sets realistic achievable outcomes with the client. Finally, the assessment stage is a time when the nurse determines whether any specific issue requires immediate attention, for example, a crying baby.
- The main goal of assessment is to agree on the formulation of a management plan with the client. It allows the nurse to educate the client about the process and to initiate change. It also allows the client to realise that they have control over the problem and their input can alleviate the symptoms of the problem.
- When assessing the problem it is important to differentiate between four major client response modes. Different assessment procedures give information regarding the different response modes. Measurement has a central role in cognitive behavioural therapy and must occur using the different assessment modes:
  1. Behavioural: assessment at interview and the development of self monitoring scales (eg mood scale, journal)
  2. Physiological;
  3. cognitive, and
  4. emotional responses.

The first and central principle of cognitive behavioural assessment is the way in which the individual behaves and this is largely determined by the immediate situation and the individual's interpretation of the situation.

During the assessment the following should be identified:

- *What are the main problems? (overt or covert)*
- *What would the client like to change?*
- *What are the precipitants for the client's problems?*
- *When does the problem occur?*
- *What are the consequences of the problem?*
- *What seems to maintain the behaviours displayed?*
- *What management strategies need to be implemented?*

**CLINICAL CASE:**

Ms Jones is a 20 year old women presenting for the second time at your clinic. She has a six week old baby son. He is her first child. She is unmarried and lives by herself in a Homeswest apartment.

She is very anxious on presentation and is unable to sit still. She states that she is not coping well with the new baby and is becoming increasingly irritated by his crying. She is not sleeping and has lost excessive weight since giving birth.

She feels that all the problems she is experiencing are her fault and that she is a failure as a mother. She talks about wanting to go around Australia on a bus to get away from it all but does not appear from her conversation to include her son in her plans.

During the interview she shows little warmth to or interaction with her son. She leaves him in his basket throughout the interview and has no eye contact with him even though he is awake and seeking attention during this time.

Apart from her stating that she becomes angry when her son cries she shows little emotion during the interview and appears flat and unresponsive to the environment and her child.

She states that she become quite anxious and angry at night when she is tired and when the baby will not settle. She asks you how she can get rid of these feelings and be a better mother to her child.

Please identify from the scenario the main features under each of the four modes:

**Behavioural:**

Physiological:

Cognitive:

Emotional responses:

Now identify:

- What are the main problems? (overt or covert)
  
- What would the client like to change?
  
- What are the precipitants for the client's problems?
  
- When does the problem occur?



- *What are the consequences of the problem?*
- *What seems to maintain the behaviours displayed?*
- *What management strategies need to be implemented?*

#### **Childbirth Stress/Postnatal Depression Workbook.**

Active involvement and participation is essential if the client wants to bring about changes based on the cognitive behavioural model.

It is important that when you work with the client to help them fill in the **NURSE** section of the workbook that you focus on positive cognitive constructions when formulating you comments.

When working through the workbook with the client it is important to once again encourage her to write her thoughts positively.



**REVIEW OF ROLE PLAY**  
**EGAN'S MODEL**

• **What are the main problems?** (overt or covert)

Jane complains to you that she is feeling tired and sad since arriving home with the new baby. She states that her husband does not help her very much with the housework and she feels that he should be doing more. However, she believes that it is really her role to care for the welfare of her family. Therefore, by the end of each day she is so tired and she has little time left for herself or interactions with her husband or children.

• **What would the client like to change?**

Jane has identified that she would like to change the way she feels at the end of the day. She would like to be able to care for her family, to have some support and to have enough energy to enjoy her interactions with her family members.

• **What are the precipitants for the client's problems?**

Jane has several stresses: a new baby, two other children, a husband who is away from home a lot, no support and she has recently moved to a new State. She also sees herself as being responsible for making a home. She believes that if she asks or receives too much help that she is not meeting her role expectations as a wife and as a mother. When she can't cope she views herself as a failure.

• **When does the problem occur?**

The problem occurs mainly in the evening when Jane is tired and the baby has difficulty in sleeping. Most nights Jane carries the baby in her arms for about two hours until the baby falls asleep. This causes her stress because she is tired and unable to spend time with herself, her other children or her husband when he is home. Her husband tells her that she should put the baby in the cot and let her cry. The doctor has said that the baby's colic is not severe and should not keep the baby awake.

• **What are the consequences of the problem?**

Jane feels more and more inadequate as a mother, wife and person. Hence she is withdrawing and her interactions with her husband are decreasing

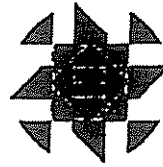
• **What seems to maintain the behaviours displayed?**

Jane's her role expectation and her social isolation.

• **What management strategies need to be implemented?**

1. Normalisation of the problem. Explain to Jane that many new mothers experience problems in role expectations and that she is no different from most women in her situation.
2. What is important to Jane. Discuss role expectations with Jane.
3. The willingness of her husband to be involved in helping his wife when he is home.
4. Possible benefits and problems associated with this change in role expectations
5. Discuss Jane's routine during the day to identify ways of decreasing her level of tiredness
6. The baby's sleeping habits need to be evaluated.
7. Is there any family or social support that is available to help Jane?

## **13.0 APPENDIX 6: Program for CBT / Solution-focussed Therapy workshop**



# Perth Clinic Programme for Post Natal Depression Workshop

**Venue:** Perth Clinic Seminar Room  
29 Havelock Street  
West Perth - Tel 94514888.  
Parking at the rear of 33 Havelock Street, West Perth

**Time:** 8.30 am - 10.30 am

**Week 1**

**13 June 2001**

Introduction to workshop  
Booklets distributed  
PND refresher - symptoms and patient presentations  
Counselling Skills

**Week 2**

**27 June 2001**

Medications - breast feeding  
(Dr Jon Rampono)  
Introduction to Solution Focussed Brief Therapy Model

**Week 3**

**4 July 2001**

Solution Focussed Therapy and its applications to Post Natal Depression

**Week 4**

**25 July 2001**

Introduction to Cognitive Behavioural Therapy  
- Model  
- Eliciting and evaluating thoughts and beliefs  
- Challenging unhelpful thoughts and beliefs.

**Week 5**

**22 August 2001**

Applying Cognitive Behavioural Therapy  
- Your case examples and practical tips

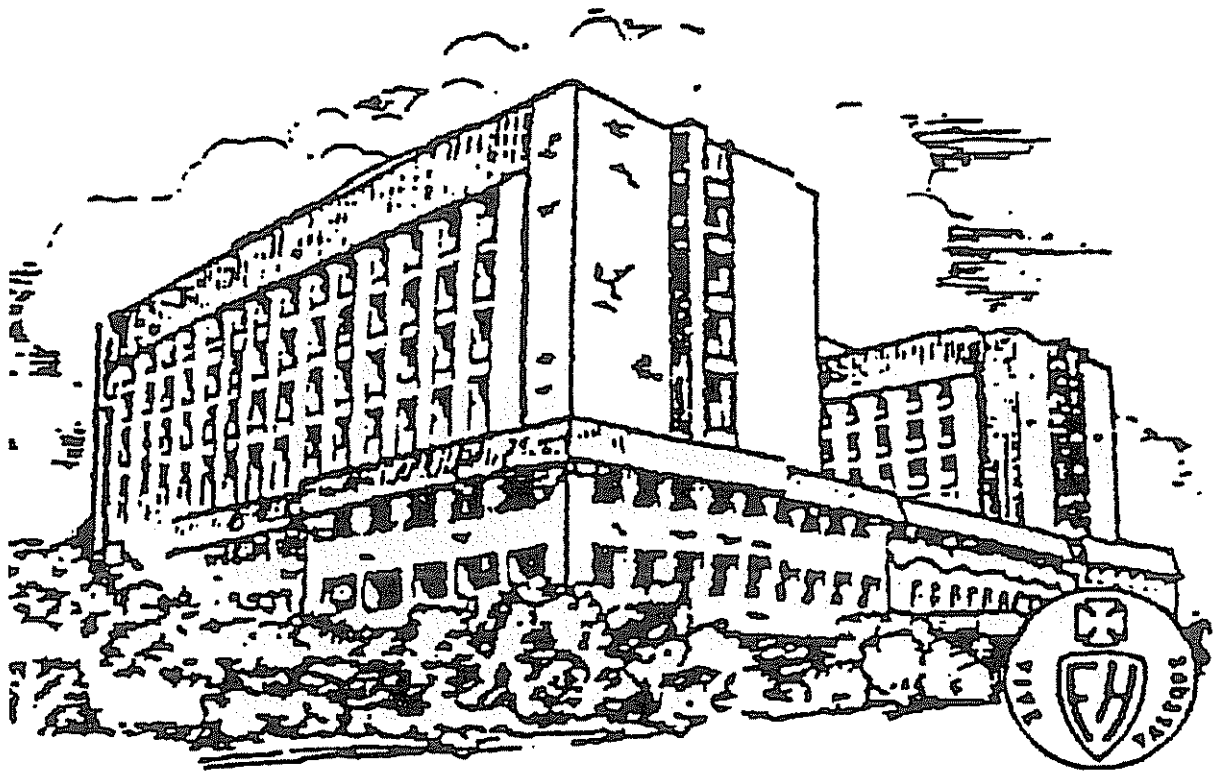
**Week 6**

**26 September 2001**

Final session  
Review of skills  
Relapse prevention strategies  
Evaluating your work.

## **14.0 APPENDIX 7: Postnatal Assessment & Management Plan**

**FREMANTLE HOSPITAL AND HEALTH SERVICE  
COMMUNITY AND WOMEN'S HEALTH SERVICES  
&  
DIRECTORATE OF MENTAL HEALTH SERVICES**



**POSTNATAL ASSESSMENT AND  
MANAGEMENT PLAN**



**POSTNATAL ASSESSMENT AND MANAGEMENT PLAN**  
**Wynaden, D., Axten, C., Downie, J., McGowan, S., Ogilvie S., Juliff, D.,**  
**Fitzpatrick, L., Zeeman, Z., Painter, S. & Kisely, S. (2000)**

NAME:

DATE:

ADDRESS:

Edinburgh Post Natal Depression Scale Score:

**1. CLIENT'S PERCEPTION OF THE POST NATAL PERIOD**

Please document your evaluation of the client's experiences in the post natal period. In particular what impact has having a baby made to her lifestyle, relationships, leisure time, support systems and her level of coping?

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**2. CLIENT'S PERCEPTION OF THE CURRENT SITUATION**

Please document your evaluation of the clients level of functioning, decision making skills, bonding issues, relationships, general appearance of mother/baby, acceptance of role, role expectations and role difficulties.

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**3. CLIENT'S EXPECTATIONS OF BEING A MOTHER**

From your assessment does the client have realistic expectations of motherhood and of her ability to care for her baby?.

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**4. COGNITIVE STYLE: (assess the cognitive style of the client when asked to provide information regarding herself, the world and the future. Is her cognitive style generally positive or is it generally negative?)**

Please detail information from you assessment regarding the client's cognitive style in particular how she views:

Herself: \_\_\_\_\_

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The World: \_\_\_\_\_

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The future: \_\_\_\_\_

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Her baby: \_\_\_\_\_  
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**5. PHYSICAL ASSESSMENT (A general description of the client's physical state. Any physical problems and/or behavioural responses. Eating and sleep patterns. Problems following delivery. Breast feeding problems, medications and alcohol and drug use)**

Please detail your evaluation of the client's physical state.

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**6. BEHAVIOURAL RESPONSES: (Not the client's behavioural responses to you during the interview. Are there any unusual, repetitive, unusual or inappropriate responses displayed?)**

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**7. EMOTIONAL RESPONSES: (Please detail the client's emotional response. Note any unusual or inappropriate responses).**

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**8 PSYCHIATRIC HISTORY (Does the client have a psychiatric history. Is the client worried that they may have a mental illness? Is there a family history of mental illness?)**

Please document relevant information

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The following section of the form is completed by the Psychiatric Consultation and Liaison Nurse and the Child Health Nurse following the completion of the assessment.

**9. EVALUATION OF SIGNS, SYMPTOMS AND BEHAVIOURS ASSOCIATED WITH POST NATAL DEPRESSION**

Please detail from the assessment the major signs, symptoms and behaviours of the client that you feel are associated with the client's current level of functioning under the following headings:

**9.1 Physical Issues (sleep patterns, eating, self care, care of the baby)**

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**9.2 Mental Status Examination (mood, thoughts, communication, behaviour, previous history of psychiatric illness, religious/cultural aspects)**

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**9.3 Risk assessment (self harm behaviours, risk to self/others, physical risk to self/others, Does the mother have any thoughts of harming the baby?)**

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**9.4 Social Factors (support, relationships, resources)**

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**10. MANAGEMENT PLAN**

Following the assessment, please outline the collaborative management plan that has been developed between the Psychiatric Consultation and Liaison Nurse, the Child Health Nurse and the client.

**10.1 What are the main problems?**

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**10.2 What would the client like to change?**

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**10.3 What are the precipitants for the client's problems?**

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**10.4 When do the problems occur?**

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**10.5 What are the consequences of the problems?**

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**10.6 What maintains the behaviours displayed?**

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**10.7 What management strategies need to be implemented?**

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**10.8 Additional comments**

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## 15.0 APPENDIX 8: Telephone Interview Schedule

# TELEPHONE INTERVIEW

Client's name:..... Date.....

This telephone interview sheet is a guide for use when contacting a client via the telephone.

On connection with the client, introduce self and ask is it convenient to proceed with the arranged telephone contact.

State the time allocation to the client to prompt start of the contact.

### *Issues to be discussed*

Ask the client for her set goals

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### *Update on progress*

Ask the client to list her practice task(s)

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Ask what worked – praise the client with positive reinforcement

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Ask what the client could have done differently

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### *Other issues of concern to the client*

Discuss any other issues the client wants to cover (use minimal prompts to help client solve any problems)

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### *Closure of telephone interview*

Review issues and strategies that have been covered in this consult. Positive reinforcement and encouragement to continue.

Reinforce any goals that the client will continue with prior to next contact

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*Thank the client for their time with this telephone interview*

*Make arrangements for next contact*

Health Professional's Name .....

Date \_\_\_\_\_ Time Started Call \_\_\_\_\_ Time Completed Call \_\_\_\_\_

**16.0 APPENDIX 9: Childbirth Stress / Postnatal Depression Workbook**

CHILD BIRTH STRESS /  
DEPRESSION



WORK BOOK

# CONTENTS

Page: 1	Contents Table
Page: 2	Brief explanation of Postnatal Stress / Depression Community Child Health Nurse Community Mental Health Nurse
Page: 3	Outline of Program
Page: 4 & 5	NURSE Guidelines and Comments
Page: 6	Postnatal Mood Evaluation Chart
Page: 7	Postnatal Depression Mood Action Chart
Page: 8	Strategies Sheet
Page: 9	Reflective Sheet

## **INTRODUCTION**

Following childbirth, mothers make a tremendous adjustment to their lives by caring for their newborn, establishing breastfeeding as well as managing home, partners and other relationships. Most women find this an emotional and intense period of their lives. Statistics show us that 20% of women will find this period of their lives much more distressing, and feelings of anxiety may increase.

The most common psychological complication of childbirth is clinical depression occurring at any time during the first year after childbirth. The onset tends to be gradual and may persist for many months. Postnatal depression includes a wide range changes involving feelings, behaviour and thoughts that lasts longer than two weeks. Postnatal depression affects the mother baby relationship as well as the whole family.

Remember, you are not alone in what you are experiencing and that professional help is available. The people able to assist you through this time are:

### **COMMUNITY CHILD HEALTH NURSE**

- provides support
- promotes positive life style changes with the use of the workbook
- provides education
- guidance in parenting.

### **COMMUNITY MENTAL HEALTH NURSE**

- assesses mood changes and feelings that you are experiencing following the birth of your baby.
- works with you and the child health nurse developing positive life style changes.

## OUTLINE OF PROGRAM

### **WEEK 1 Child Health Centre appointment**

- Meeting with the community child health and mental health nurses.
- The workbook will be given to you, the use of the workbook will be explained.
- A home visit will be scheduled for the following week.
- This visit also includes viewing of a video on postnatal depression.

### **WEEK 2 Home visit by Community Child Health Nurse,**

- During this visit the nurse will go through the workbook with you, and provide information, counselling and support relevant to your needs.
- The nurse will also discuss parenting issues and provide information on what to expect from your baby as he/she grow and develops.
- At the completion of the home visit the nurse will make an appointment for a follow up telephone visit in the following week. This is expected to last 15 minutes.

### **WEEK 3 A follow up telephone visit by the Community Child Health Nurse.**

- During this visit the nurse will discuss your action chart in your workbook.
- At the end of the telephone conversation the nurse will make an appointment to home visit you in the following week.

### **WEEK 4 Home visit by the Community Child Health Nurse.**

- The workbook will be used as the basis for the visit. Further education and support will be provided.
- This session will take approximately 45 minutes.
- At the conclusion of the visit a further appointment will be made for a telephone visit in the following week.

### **WEEK 5 A follow up telephone visit.**

- This telephone visit will be conducted using your action chart in your workbook.
- This telephone visit will take approximately 15 minutes.
- An appointment will be made for you to attend the child health centre the following week.

### **WEEK 6 Child Health Centre appointment.**

- At this visit further support and education is carried out
- You will also be asked to fill out 2 questionaries.
- At the completion of this visit an appointment will be made for a follow up child health centre appointment in 3 months time.

### **WEEK 12 Child Health Centre appointment.**

- Client monitoring

### **WEEK 18 Child Health Centre appointment.**

- Completion of EPDS and Quality of Life Index



GUIDELINES	COMMENTS
<p><b>N = NUTURE</b></p> <ul style="list-style-type: none"> <li>• Nutrition      Food                          Vitamins/herbals/supplements                          Alcohol &amp; Drug intake/use</li> <li>• Medications</li> <li>• Social Network    Baby                          Partner                          Family                          Friends                          Associations</li> <li>• Self                    Body                          Changing roles</li> </ul> <p><b>U = UNDERSTANDING CHILD BIRTH STRESS</b></p> <ul style="list-style-type: none"> <li>• You are an individual with your own feelings, thoughts &amp; emotional needs &amp; sometimes these can be conflicting</li> <li>• Appreciate the impact of a new person on you &amp; your family's lifestyle</li> <li>• Engaging your intellect &amp; creativity</li> <li>• Parenting knowledge    Realistic expectations &amp; limitations</li> <li>• Baby growth &amp; development information</li> <li>• Accept support from others</li> </ul>	

GUIDELINES	COMMENTS
<p><b>R = RELAXATION</b></p> <ul style="list-style-type: none"> <li>• Adjusting your sleep pattern, rest periods</li> <li>• Allowing time out for self mentally &amp; physically</li> <li>• Relaxation practices      Breathing techniques   Visualisation   Meditation</li> <li>• Individual strategies    Read a book   Have coffee with a friend</li> </ul> <p><b>S = SPIRITUAL CONCEPTS</b></p> <ul style="list-style-type: none"> <li>• Nature appreciation</li> <li>• Belief in a higher power</li> <li>• Soul nurture</li> <li>• Meaningful experiences</li> </ul> <p><b>E = EXERCISE</b></p> <ul style="list-style-type: none"> <li>• Routine for exercise</li> <li>• Activity that is enjoyed</li> <li>• Exercise group</li> </ul>	

## POSTNATAL MOOD EVALUATION CHART

Please try to complete this chart at the same time each day. It will enable you to keep a record regarding whether or not there is any change in how you are feeling, thinking and coping. (You are making contact once a week; discuss outcomes then.)

For each feeling, behaviour and thought listed below, please indicate using the key whether or not particular feelings, thoughts or behaviours are present for you each day:

0	1	2	3	4
Never	Rarely	Occasionally	Often	All the time

Month Date								
<b>Feelings</b>								
Low mood								
Inadequacy, failure, hopeless, helpless								
Exhausted								
Empty								
Sad								
Tearful /crying								
Guilt, shame, worthless								
Confused								
Anxious								
Panicky								
Frightened of being alone								
Fear of going out								
Fear for baby								
<b>Behaviour</b>								
Lack of interest in usual activity								
Sleep, too little or too much								
Eating – more or less								
Decreased energy and motivation								
Not taking care of self								
Unable to cope with routine tasks								
<b>Thoughts</b>								
Unable to think clearly								
Unable to concentrate								
Poor memory								
Of hurting myself								
Of hurting my baby								

## POSTNATAL DEPRESSION - ACTION CHART

**Remember:** Be active, although it feels tempting to stay in bed or be inactive, give yourself a chance to do more. At first you may not feel like doing things, but as you become more active, it will become easier. You can help by making only reasonable demands on yourself. Keep each day simple. Avoid unnecessary tasks and pressures. Involve others in your day. Spend time with others. Where possible put off making important decisions until you feel your mood has lifted.

To enable you to use new ways of coping, it may help to record some of your responses and what you did at the time.

If it worked - great - do it again.

If it didn't - think about what else you can do next time.

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When I feel

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I can do

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It worked    Yes    No    Unsure

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When I feel

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I can do

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It worked    Yes    No    Unsure

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Cleaning & scrubbing  
can wait till tomorrow..  
for babies grow up  
we've learned to  
our sorrow.....

So quiet down  
cobwebs.....

dust go to sleep.....

I'm rocking my baby, and  
babies don't keep !!!!

GUIDELINES	COMMENTS
<p><b>N = NUTURE</b></p> <ul style="list-style-type: none"> <li>• Nutrition      Food Vitamins/herbals/supplements Alcohol &amp; Drug intake/use</li> <li>• Medications</li> <li>• Social Network    Baby Partner Family Friends Associations</li> <li>• Self              Body Changing roles</li> </ul> <p><b>U = UNDERSTANDING CHILD BIRTH STRESS</b></p> <ul style="list-style-type: none"> <li>• You are an individual with your own feelings, thoughts &amp; emotional needs &amp; sometimes these can be conflicting</li> <li>• Appreciate the impact of a new person on you &amp; your family's lifestyle</li> <li>• Engaging your intellect &amp; creativity</li> <li>• Parenting knowledge    Realistic expectations &amp; limitations</li> <li>• Baby growth &amp; development information</li> <li>• Accept support from others</li> </ul>	



GUIDELINES	COMMENTS
<p><b>R = RELAXATION</b></p> <ul style="list-style-type: none"> <li>◦ Adjusting your sleep pattern, rest periods</li> <li>◦ Allowing time out for self mentally &amp; physically</li> <li>◦ Relaxation practices      Breathing techniques   Visualisation   Meditation</li> <li>◦ Individual strategies    Read a book   Have coffee with a friend</li> </ul> <p><b>S = SPIRITUAL CONCEPTS</b></p> <ul style="list-style-type: none"> <li>◦ Nature appreciation</li> <li>◦ Belief in a higher power</li> <li>◦ Soul nurture</li> <li>◦ Meaningful experiences</li> </ul> <p><b>E = EXERCISE</b></p> <ul style="list-style-type: none"> <li>◦ Routine for exercise</li> <li>◦ Activity that is enjoyed</li> <li>◦ Exercise group</li> </ul>	

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Anxious						
Panicky						
Frightened of being alone						
Fear of going out						
Fear for baby						
<b>Behaviour</b>						
Lack of interest in usual activity						
Sleep, too little or too much						
Eating – more or less						
Decreased energy and motivation						
Not taking care of self						
Unable to cope with routine tasks						
<b>Thoughts</b>						
Unable to think clearly						
Unable to concentrate						
Poor memory						
Of hurting myself						
Of hurting my baby						

## POSTNATAL DEPRESSION - ACTION CHART

**Remember: Be active, although it feels tempting to stay in bed or be inactive, give yourself a chance to do more. At first you may not feel like doing things, but as you become more active, it will become easier. You can help by making only reasonable demands on yourself. Keep each day simple. Avoid unnecessary tasks and pressures. Involve others in your day. Spend time with others. Where possible put off making important decisions until you feel your mood has lifted.**

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When I feel

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It worked    Yes    No    Unsure

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When I feel

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It worked    Yes    No    Unsure

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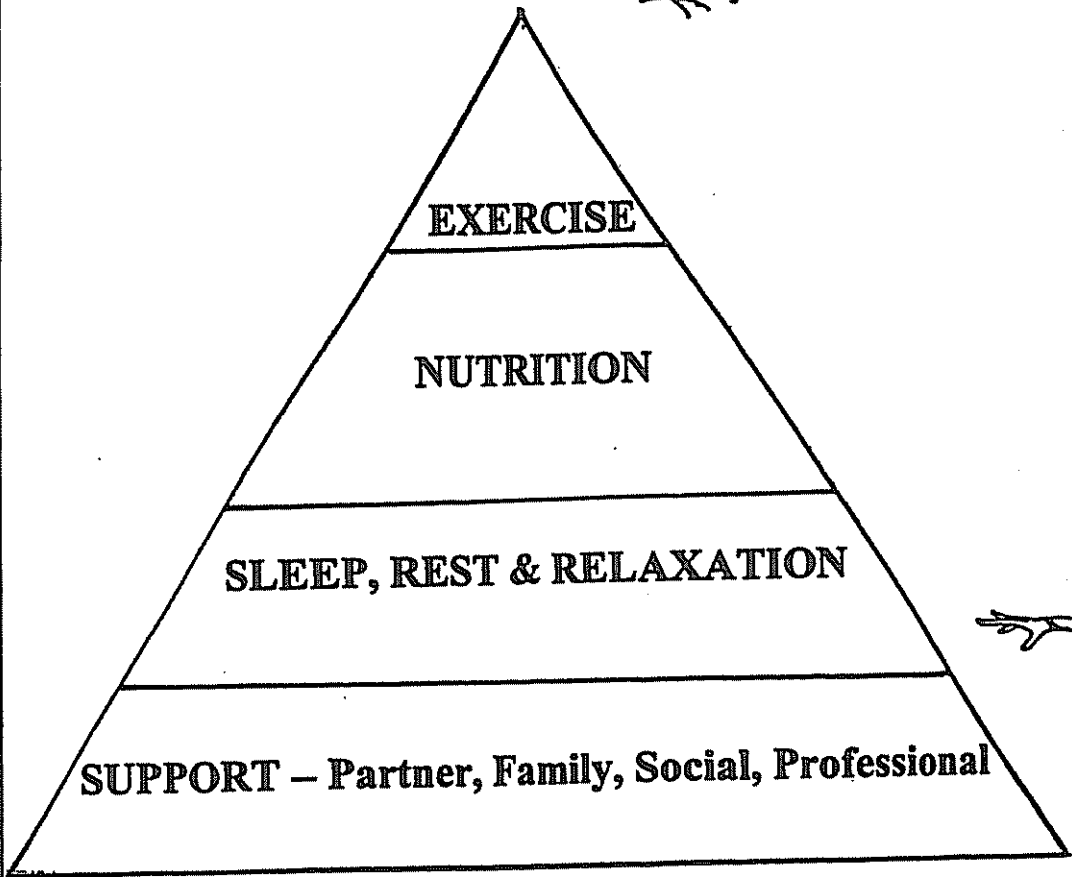




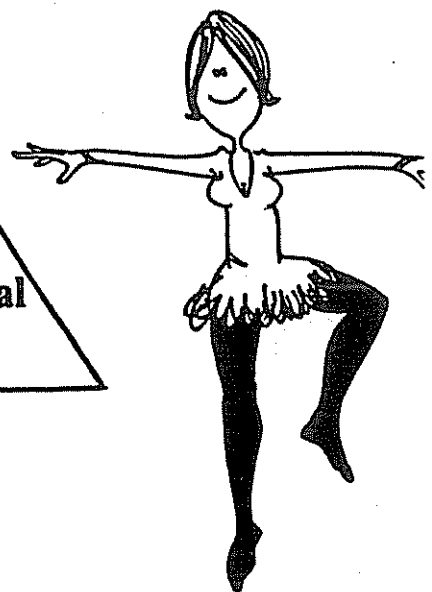
"He can sense when you're not relaxed."



neil



**Pyramid for Maternal Survival**



GUIDELINES	COMMENTS
<p><b>N = NUTURE</b></p> <ul style="list-style-type: none"> <li>• Nutrition      Food Vitamins/herbals/supplements Alcohol &amp; Drug intake/use</li> <li>• Medications</li> <li>• Social Network    Baby Partner Family Friends Associations</li> <li>• Self              Body Changing roles</li> </ul> <p><b>U = UNDERSTANDING CHILD BIRTH STRESS</b></p> <ul style="list-style-type: none"> <li>• You are an individual with your own feelings, thoughts &amp; emotional needs &amp; sometimes these can be conflicting</li> <li>• Appreciate the impact of a new person on you &amp; your family's lifestyle</li> <li>• Engaging your intellect &amp; creativity</li> <li>• Parenting knowledge    Realistic expectations &amp; limitations</li> <li>• Baby growth &amp; development information</li> <li>• Accept support from others</li> </ul>	

GUIDELINES	COMMENTS
<p><b>R = RELAXATION</b></p> <ul style="list-style-type: none"> <li>• Adjusting your sleep pattern, rest periods</li> <li>• Allowing time out for self mentally &amp; physically</li> <li>• Relaxation practices      Breathing techniques    Visualisation    Meditation</li> <li>• Individual strategies    Read a book    Have coffee with a friend</li> </ul> <p><b>S = SPIRITUAL CONCEPTS</b></p> <ul style="list-style-type: none"> <li>• Nature appreciation</li> <li>• Belief in a higher power</li> <li>• Soul nurture</li> <li>• Meaningful experiences</li> </ul> <p><b>E = EXERCISE</b></p> <ul style="list-style-type: none"> <li>• Routine for exercise</li> <li>• Activity that is enjoyed</li> <li>• Exercise group</li> </ul>	



## POSTNATAL MOOD EVALUATION CHART

Please try to complete this chart at the same time each day. It will enable you to keep a record regarding whether or not there is any change in how you are feeling, thinking and coping. (You are making contact once a week; discuss outcomes then.)

For each feeling, behaviour and thought listed below, please indicate using the key whether or not particular feelings, thoughts or behaviours are present for you each day:

0	1	2	3	4
Never	Rarely	Occasionally	Often	All the time

Month Date						
<b>Feelings</b>						
Low mood						
Inadequacy, failure, hopeless, helpless						
Exhausted						
Empty						
Sad						
Tearful /crying						
Guilt, shame, worthless						
Confused						
Anxious						
Panicky						
Frightened of being alone						
Fear of going out						
Fear for baby						
<b>Behaviour</b>						
Lack of interest in usual activity						
Sleep, too little or too much						
Eating – more or less						
Decreased energy and motivation						
Not taking care of self						
Unable to cope with routine tasks						
<b>Thoughts</b>						
Unable to think clearly						
Unable to concentrate						
Poor memory						
Of hurting myself						
Of hurting my baby						

## POSTNATAL DEPRESSION - ACTION CHART

**Remember: Be active, although it feels tempting to stay in bed or be inactive, give yourself a chance to do more. At first you may not feel like doing things, but as you become more active, it will become easier. You can help by making only reasonable demands on yourself. Keep each day simple. Avoid unnecessary tasks and pressures. Involve others in your day. Spend time with others. Where possible put off making important decisions until you feel your mood has lifted.**

To enable you to use new ways of coping, it may help to record some of your responses and what you did at the time.

If it worked - great - do it again.

If it didn't - think about what else you can do next time.

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When I feel

.....  
.....  
.....  
.....

I can do

.....  
.....  
.....  
.....

It worked      Yes    No    Unsure

---

When I feel

.....  
.....  
.....  
.....

I can do

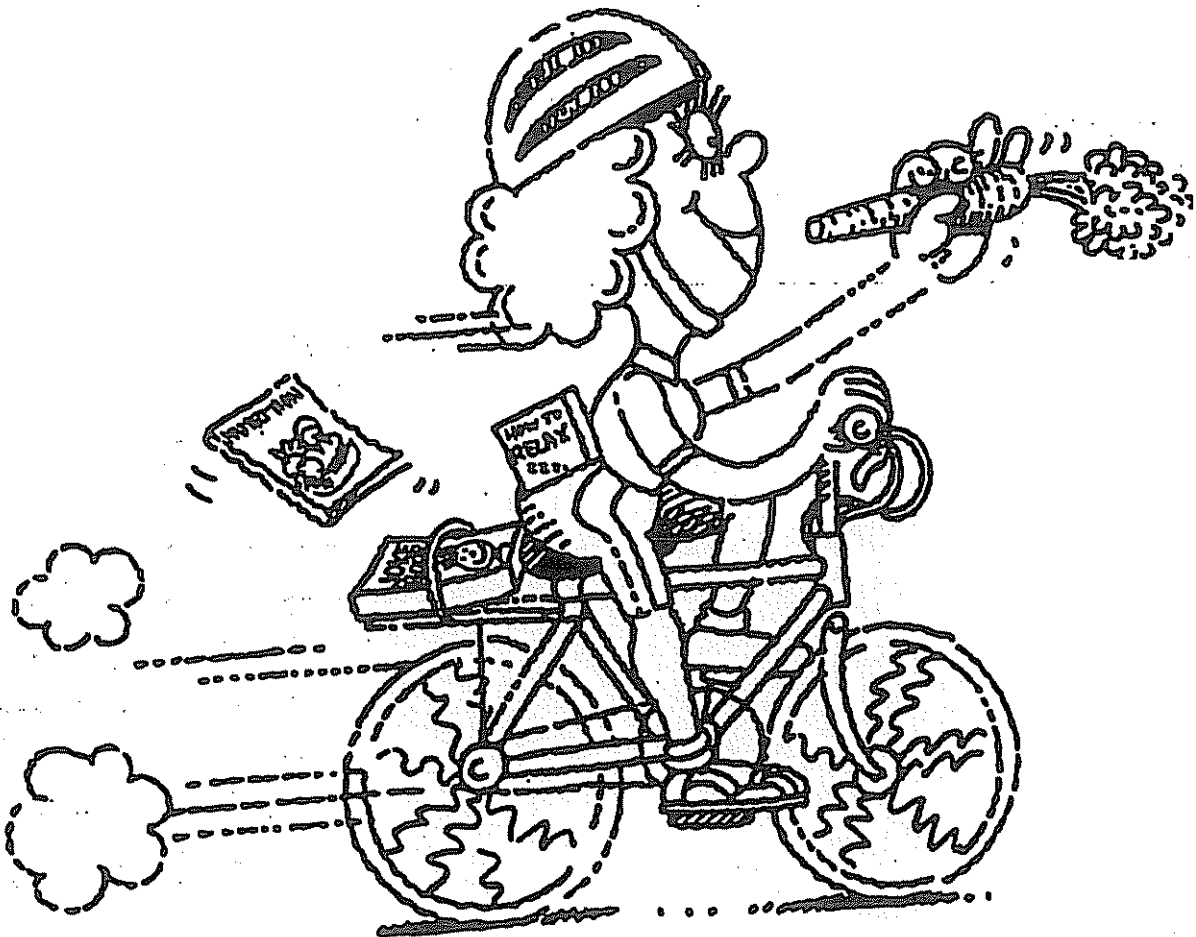
.....  
.....  
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It worked      Yes    No    Unsure

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*"We need a range of skills to use in specific circumstances"*