

**EXPLORING ENGAGEMENT IN AN ANTENATAL
PSYCHOSOCIAL INTERVENTION FOR THE PREVENTION OF
POSTNATAL DEPRESSION**

Thesis submitted for the degree of

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by

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Exploring Engagement in an Antenatal Psychosocial Intervention for the Prevention of Postnatal Depression.

Sandra L Wheatley

ABSTRACT

The aim of this thesis was to investigate engagement in the antenatal psychosocial intervention 'Preparing for Parenthood' designed to reduce postnatal depression, run within the current maternity system, to identify factors predictive of engagement. The quantitative study investigated three components of health-promotion behaviour: health locus of control, social support and negative life events within an ongoing randomised controlled trial (RCT). A qualitative study, using the technique of grounded theory, was carried out after the quantitative study had been completed. In the quantitative study (n=1300), women were identified as at risk of postnatal depression by a screening questionnaire, 'Pregnancy and You', at 15-20 weeks gestation (n=400). A baseline assessment was completed 4 weeks later (n=292). Women who wished to have the opportunity to attend the intervention were randomised to an intervention (n=103) or control condition (n=106). The intervention consisted of six, 2-hour sessions held every week preceded by an initial introductory meeting and followed by a postnatal reunion session at the Leicester General hospital, run by two female course leaders whose backgrounds were in mental health. An outcome assessment of measures of engagement was completed at 3 months postnatally with all willing participants. In the qualitative study (n=82), the procedures used followed that of the quantitative study where appropriate. The same psychosocial intervention (n=15) was implemented. The outcome interview was completed between two and three months postnatally and consisted of 9 questions (n=12). The intervention package was considered to have been reliably presented across the time period of the study. The only significant result of the quantitative study in relation to engagement was that the women who declined to be randomised (refusers) had significantly less contact with the NHS in the 12 months prior to the baseline assessment than either the compliant or the non-compliant participants. However, no significant differences were found between the compliant and non-compliant participants (randomised to the intervention) for the factors investigated. Analysis using the grounded theory technique identified two main categories of themes, clustering at either the screening stage or at the intervention stage itself. Seven themes were identified as influential in *initiating* engagement with the intervention; and eight themes were identified as being influential in *maintaining* engagement with the intervention. It was concluded that actual health-promotion behaviour was not predictable using the three hypothesised measures of prediction, in this population, and for this intervention. The findings of the qualitative study enabled potential improvements to the intervention to be identified as possible ways of gaining and maintaining participant interest, and therefore engagement.

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1. INTRODUCTION

The work described in this thesis is aimed at evaluating potential reasons for differing rates of participation amongst women in their intended uptake and actual attendance of an antenatal psychosocial intervention for the prevention of postnatal depression. This chapter will address the main outcome variables measured. It reviews the psychological theories/models relating to those parameters, previous research undertaken with respect to health behaviour in general, and in women in particular. It will review psychological research carried out during pregnancy and the first postpartum year. The thesis discusses the theories related to health-promoting behaviour and the cognitive mediators thought to be involved. The components of health-promoting behaviour are then considered focusing on health locus of control, psychosocial support and negative life events. The rationale for a novel empirical study is then provided. The chapter begins with an introduction to the study context in which perinatal psychiatric disorders are outlined, with particular emphasis on postnatal depression (PND).

1.1 *Perinatal Psychiatric Disorders*

There are three main disorders of the puerperium. In order of increasing severity, they are the blues, postnatal depression (PND), and puerperal psychosis.

1.1.2 Blues

The blues is a term describing postnatal mood changes which are so common in western culture that they are often regarded as a natural part of childbirth. The symptoms of the blues have been described as including "dysphoria, mood lability, crying, anxiety, insomnia, poor appetite, and irritability" (O'Hara, Schlechte, et al. 1991, p.801).

O'Hara *et al.* (1991, p801), state that "The postpartum blues refers to a mild syndrome typically experienced by women within the first week to 10 days after delivery (O'Hara, 1987; Pitt, 1973; Yalom *et al.*, 1968) ... Prevalence of the postpartum blues has ranged from 26% to 85% (Stein *et al.*, 1981). Criteria for the blues, which have not been well established, range from simply crying for at least 5 minutes during the first 10 days postpartum (Yalom *et al.*, 1968) to the presence of several symptoms to at least a mild degree (O'Hara *et al.*, 1990)". The authors concluded that predictors of the blues included a personal and family history of depression, social adjustment and negative life events.

There is also evidence that the blues appear to be an affective syndrome specific to childbirth and not just a non-specific response to a major stressor (Iles *et al.* 1989; Kendell *et al.*, 1984; though see Yalom *et al.*, 1968; and Levy, 1987). O'Hara *et al.* (1990) found that the blues was much more common in a group of childbearing women (26.4%) than a matched control group of nonchildbearing women (7.3%).

There have been several reviews of the literature examining the reported associations between the blues and PND. The severity and frequency of symptoms and the timing of the course of the disorder can be used to distinguish between the blues and PND. However, experiencing prolonged or severe postpartum blues can be an indicator of increased vulnerability to PND (Kendell *et al.*, 1981; Paykel *et al.*, 1980; Morsbach & Gordon, 1984; Hapgood *et al.*, 1988).

1.1.2 Postnatal Depression

Postnatal depression (PND) is generally considered to have its onset any time from the first week after delivery. It has been reported to last 20 weeks after birth (Oakley & Chamberlain, 1981), up to 1 year after birth (Pitt, 1968), or beyond the first year (Nott, 1987), and could even continue to be present in varying degrees of severity for up to six years after the child is born (Kumar & Robson, 1984; Coleman *et al.*, 1986). England *et al.* (1994) found that the likelihood of PND becoming a chronic illness was increased if the delay before adequate treatment was received was prolonged. They went on to conclude that early treatment should be encouraged. This requires early identification and the re-education of not only mothers-to-be but also the health professionals with whom they come into contact.

Raphael-Leff (1991, p.482) suggests that some of the most common symptoms that a woman feels are “a sense of being ineffectual and a failure; feelings of profound self-depreciation; worthlessness and guilt at not having lived up to her own expectations; fear of judgement and criticism by others and shame at being depressed rather than elated and joyful ... anxieties about the baby's well-being and fears of harming him/her either psychologically, or physically, or being harmed by the baby”. Psychosocial predictors of PND number amongst them: poor antenatal and/or postnatal social support, antenatal depression, and extreme early postnatal dysphoria (blues). Obstetric predictors have included caesarean section delivery (Edwards *et al.*, 1994). Seasonal variations have also been suggested, the onset of PND being found to be more prevalent in the Autumn than at any other time of year (Ballard *et al.*, 1993).

Although there is some debate about the term ‘postnatal depression’, and the concept itself, (which will not be addressed here), its consequences can be serious. Postnatal depression is

particularly problematic as it occurs at a time when enormous demands are placed on a woman, and it can have long-term effects on the woman and her family. Elliott, 1989, p.879) states that "depression after childbirth may:

1. Fundamentally and enduringly undermine a woman's self-esteem, particularly her confidence in her ability to be a "good enough" mother.

- 2 Be a permanent and well-remembered source of regret, since women describe having 'missed the first year' of their child's life.

- 3 Delay the development of mother-infant attachment and mutually satisfying interactive behaviours.

4. Lead to long-term effects on the child's behaviour or cognitive ability, as well as the mother/child relationship, if the mother's 'withdrawal' is not adequately compensated for by the father or other suitable persons.

- 5 Lead to marital stress and, if this remains unresolved, eventually divorce."

PND and clinical depression in women have been found to be equally prevalent (Brockington, 1992; Cox *et al.*, 1993). However, PND is qualitatively different from clinical depression and is described by Pitt (1968) as 'atypical'. Cooper & Murray (1995) established that the causative factors of non-psychotic PND are not the same as causative factors for depression at other times - their findings suggest a specific nosologic reference for the concept of PND.

Somatic symptoms commonly associated with PND, such as difficulty sleeping; early morning wakening; loss of appetite and weight; are included in many scales assessing clinical depression. Many of the symptoms that are present in mothers with PND are also present to a lesser extent in mothers who are not diagnosed as postnatally depressed. For example, tiredness, irritability, and loss of appetite are widely experienced by many women at this time in their lives. Indeed, some researchers have questioned the relationship between some of these somatic symptoms and PND. For example, Caltabiano & Caltabiano (1996) suggested that physical exhaustion due to women's multiple roles and sleep deprivation at this time may be an effect, rather than a descriptor, of PND (Caltabiano & Slomka, 1995). They concluded in their 1996 study that "physical exhaustion and self-reports of having experienced PND are related, but they are not necessarily one and the same thing" (p.226). Therefore these and other studies have found that because of the different emphasis and expectations of what it is normal (or abnormal) to feel in the postnatal period, emotional well-being at this time has been found to require its own specific measures (Harris *et al.*, 1989). The most widely used measure in community samples is the Edinburgh Postnatal Depression Scale

(EPDS, Cox *et al.*, 1987) which emphasises anhedonia - the lack of ability to experience pleasure - and has no items with somatic content to increase the tool's diagnostic specificity with respect to PND.

PND is quoted by the Royal College of Psychiatrists in their "Postnatal depression - help is at hand" leaflet (1994, p.2) as affecting "no less than one in ten women". Zerkowicz & Milet (1995, p.80) investigated the prevalence of PND in a Canadian sample by telephone screening both multi- and primagravidas. It was "estimated to be 6.2% using a cut-off point of 10 on the EPDS, and 3.4% using the more stringent cut-off point of 12". However, this study is not representative as all single mothers were excluded from the analysis. Webster *et al.* (1994, p.44) found that "The prevalence of major depressive disorder amongst the women was 7.8% with a further 13.6% of women experiencing more minor depressive symptoms". Again, however, this sample of New Zealand multi- and primagravidas was flawed as all Asian women - approximately one third of the sample - were excluded on the grounds that "English was the second language". Therefore, taking into account the nature of the samples said to be representative of the general population, the average of one in ten or more would appear to be on the conservative side as single parenthood and lower social class (extrapolated from the inability to fluently communicate in English) are two of the most widely accepted social predictors of both PND and clinical depression. Thus the incidence suggested above may be lower than the actual prevalence rate.

1.1.3 Puerperal Psychosis

This was described by Brockington (1992, p.41) as "an acute psychosis, usually starting within the first two weeks after parturition and taking the form of an affective or schizoaffective disorder. It is at present thought to be related to manic depression. Its frequency, at the level of severity requiring hospital admission, is about one in five hundred pregnancies". Due to its relative rarity and, more importantly, its severity and thus concomitant ethical responsibilities and difficulties, this disorder is not examined in this investigation.

1.1.4 Focus on Postnatal Depression

Engagement in an intervention to prevent PND is a particularly important issue in view of the relatively high incidence of PND, its serious impact upon the lives of women and families, the availability and acceptability of measures to screen for vulnerability to PND, and the volume and reliability of research identifying (psychosocial) predictors when compared with the two other

disorders of the puerperium. The thesis extends previous work by examining and evaluating participation in the intervention.

1.2 Psychological Predictors of Health-Promoting Behaviour

This section will address the general theories and models that have been developed to try to explain the cognitive processes involved in predicting behaviour, with particular reference to health and health enhancing behaviours. This will be discussed in two parts, with respect to intentional behaviour and actual behaviour. Empirical evidence to predict engagement in health-promoting behaviours will be addressed. The structure of the present study is such that it enables exploration of the issue of the contrasts between intended behaviour and actual behaviour with regard to the prevention of postnatal depression by comparing participants who actually attend all parts of an intervention with others who intend to but do not. Also considered are the individual differences that act as cognitive mediators to influence the relationship between intended and actual behaviour, and which may therefore affect engagement in health promotion activities.

It should be borne in mind that the research in this field has found that gender differences operate in numerous ways in the field of health promotion. To attempt to ensure clarity and maintain relevance this thesis will address where possible studies with female participants. Throughout the remainder of the introduction particular emphasis is placed on studies relating to the fields of obstetrics and gynaecology, mental health, and both of these fields of research where available.

1.2.1 General Theories and Models of Health-Promoting Behaviour

Earlier social-cognitive models which were offered as explanations of health-related behaviour concentrated on individuals' *intentions* to carry out particular actions. These were criticised due to their inability to predict *actual* health behaviours - which was, in fairness, something they were not designed to predict. More recently developed models have attempted to address the topic of predicting actual behaviour with respect to health and, as a consequence, have greater real world value in their application.

1.2.1.1 Predicting Intentional Health-Related Behaviour

There are two main models that have been frequently used and evaluated to predict intentional health-related behaviour: the Health Belief Model (HBM, Becker, 1974) and the theory of reasoned action (Ajzen & Fishbein, 1980).

The HBM is principally based upon two related appraisal processes: the threat of illness, and the behavioural response to the threat. Bennett & Murphy (1997) argue that the appraisal of the threat comprises a combination of the individual's perceived susceptibility to an illness and its anticipated severity. The evaluation of the behavioural response requires consideration of the balance of profit and loss of engaging in behaviours thought to be likely to reduce the threat of disease. The model also emphasises the importance of environmental cues when making health-related decisions. The HBM incorporates six variables, each independently contributing to the decision-making process. These are: perceived susceptibility, perceived severity, health motivation, perceived benefits, perceived barriers, and cues to action.

According to Rosenstock *et al.* (1988), who evaluated, and as a result reformulated, the model; the HBM is based on the assumption "that health-related action depends upon the simultaneous occurrence of three classes of factors:

1. "The existence of sufficient motivation (or health concern) to make health issues salient or relevant.
2. The belief that one is susceptible (vulnerable) to a serious health problem or to the sequelae of that illness or condition. This is often termed perceived threat.
3. The belief that following a particular health recommendation would be beneficial in reducing perceived threat, and at a subjectively acceptable cost. Cost refers to perceived barriers that must be overcome in order to follow the health recommendation; it includes, but is not restricted to, financial outlays" (p.177).

The theory of reasoned action of Ajzen & Fishbein (1980) suggested that the intention to engage in a behaviour is the primary determinant of the behaviour being carried out. However, the theory assumes that the individual has the resources, skills, and/or opportunities to engage in the desired action and this is often not the case in everyday life. Consequently, Ajzen in (1985) included an additional dimension to try and account for real-world situations, that of control over the intended behaviour, and renamed the model "the theory of planned behaviour". Both of these models are general models of behavioural decision-making i.e. not specific to health-related issues. Nonetheless, the theory of planned behaviour has been applied to the prediction of a variety of health-related issues including condom use (Terry *et al.*, 1993) and oral contraceptive use (Doll & Orth, 1993). More recently, in Bennett & Murphy's (1997) reporting of Ajzen's (1991) review of studies evaluating the theory of planned behaviour, weak relationships were found between intentions and actual behaviour. One area of weakness that needed to be addressed is that the

model does not take into account factors such as the context in which the observed behaviour occurred. If this weakness were to be addressed, actual behaviour might have been accurately predicted. However, other researchers have chosen to develop models specific to the criteria of *actual* health-related behaviour rather than reformulate the models, such as these two examples, designed to predict *intentional* health-related behaviour.

1.2.1.2 Predicting Actual Health-Related Behaviour

The Pender Health Promotion Model (HPM; Pender 1987) is used to predict actual health-related behaviour using the Health-Promoting Lifestyle Profile (HPLP; Walker *et al.*, 1987). It has its roots in social learning theory, and thus emphasises “the cognitive mediating processes in the regulation of behaviour” (Pender 1987, p.60). Whilst resembling the HBM in structure the HPM, using some of the HBM variables in combination with new others, predicts the likelihood of individuals actually engaging in a health-promoting behaviour (Pender *et al.*, 1988).

The HPM shows that in prediction of participation in health-promoting behaviour cognitive-perceptual factors and modifying factors are highly influential. The cognitive-perceptual factors included in the HPM are: importance of health, perceived control of health, perceived self-efficacy, definition of health, perceived health status, perceived benefits of health-promoting behaviours, and perceived barriers to health-promoting behaviours. Many of these are similar in concept to the HBM’s six variables that contribute independently to the decision-making process. The modifying factors specified in the model are: behavioural factors such as previous experiences; situational (or contextual) factors; interpersonal influences; demographic characteristics such as age and gender; and biological factors such as weight.

Frauman & Nettles-Carlson (1991) found support for the HPM in their study of the self-reported health-promoting lifestyle profile of 130 well adults in a primary care setting. The behaviours measured by the HPLP included such items (out of 48) as taking time for relaxation and eating regularly. They defined health “eudiamonistically, that is, as exuberant well-being (rather than adaptive, functional or absence of disease)” (p.174) and found that, amongst other variables, chance health locus of control was negatively correlated with an individuals health-promoting lifestyle. They concluded that “considerations of a clients’ health conception when framing health promotion messages is warranted” (p.174), something that was attempted when developing the intervention for the target population of the present study.

1.2.2 Individual Differences that act as Cognitive Mediators

There follows an extract from Bennett & Murphy (1997, p.40) in contemplation of the cognitive mediators of decisions made regarding health promoting behaviours.

“The perception of personal vulnerability to disease is an important initiator of preventive behaviours. Accordingly, many health promotion programmes have attempted to raise awareness of the risks to health associated with certain behaviours. When faced with such information, the individual is faced with the task of deciding the magnitude and relevance of that risk to them. Most people do not have, or indeed want, access to unbiased or full information through which to arrive at a considered judgement.”.

The cognitive mediator that is of relevance to this thesis is that of ‘monitors’ and ‘blunters’ which is the notion that people can be divided into either seekers or avoiders of information.

1.2.2.1 ‘Monitors’ and ‘Blunters’

Miller & Mangan (1983) studied 40 gynecologic patients under-going colposcopy who were divided into information seekers (monitors) and information avoiders (blunters) using the Miller Behavioural Style Scale (MBSS). Half of each were given either a standard low level of information or a high level of information at their pre-operative consultation. Measures were taken of subjective, physiological and behavioural arousal and discomfort. "Overall, low-information patients expressed less subjective arousal than high-information patients, and blunters showed less subjective and behavioural arousal than monitors. In addition, patients level of psychophysiological arousal was lower when the level of preparatory information was consistent with their coping style; that is, blunters were less aroused with low information and monitors were less aroused with high information" (p.223). Steptoe & O'Sullivan (1986) followed this work up using the MBSS to divide 71 women about to undergo gynaecological procedures, ranging from hysterectomy to dilatation and curettage, into monitors and blunters. They concluded that " blunters' satisfaction with the information provided was a product of their avoidant coping style. The study provided support for the hypothesis that monitors will engage in more vigorous health-related information-seeking behaviours" (p.144). The inference drawn was that the relationship between desire for information about stressful medical procedures, self-reported 'understanding' of these medical procedures, and level of factual knowledge was influenced by coping style.

With respect to emotional well-being and health promotion in the antenatal period, a recent study by Michie *et al.* (1997) looked at patient decision making when the information presented to pregnant women varied in the depth of the explanation provided accompanying the screening test

for Down syndrome. The four treatment conditions were: simple leaflet only, simple leaflet and video, expanded leaflet, and finally, expanded leaflet and video. These were given out by midwives for the women to look at at home. The outcomes measured were: knowledge, change in knowledge, process of decision making, test uptake, anxiety, change in anxiety, and satisfaction with decision made. They found that there were no significant differences between the treatment conditions for any of the outcomes they measured. A criticism of the study relevant to this thesis is that the researchers did not incorporate any kind of randomisation of participants to control for the distribution of monitors and blunders between the treatment conditions. If they had been stratified for coping style or health-related information seeking behaviour conclusions could be more confidently drawn. It would be interesting to repeat this study with this design modification to target particular coping styles with different levels of Down syndrome screening information.

1.3 Psychological Components of Health-Promoting Behaviour Under Investigation

The structure of each section of this part of the introduction to the thesis follows the chronological order of the research. It commences with the development of the factor in general, the factor as it is applied to the area of health promotion, specifically, womens' (mental) health, and in particular in relation to pregnancy and postnatal depression.

The three factors that will be explored in the present research with respect to engagement in health protective behaviours are: locus of control, psychosocial support, and negative life events. There are many other factors that are thought to influence engagement in health-promotion activities. These three factors were investigated in the present study as much of the published research has not examined this area in much detail in relation to pregnancy and PND, and where empirical evidence is available it is not yet conclusive.

1.3.1 Locus of Control

This section outlines the general theories that have been put forward as health locus of control (HLOC) research has developed. The measures designed for its application are also outlined. Of particular relevance to the present study is the Fetal Health Locus of Control scale (FHLC) and studies using this measure are discussed.

The basic concept of locus of control refers to a general expectation that behaviour as well as events are controlled by internal or external forces. Rotter (1954) developed the notion, based on his social learning theory, that the likelihood of a specific behaviour occurring in a given situation is a function of the expectancy that the behaviour will lead to a particular reinforcement in that

situation and the value of that reinforcement to the individual. Seligman (1973) argued that 'internals' believe that their own actions control their lives while 'externals' believe that control of life comes from outside themselves and so attribute behaviour and events to luck and chance. An individual's locus of control has been found to alter over time as their beliefs are formed through attributions regarding previous and ongoing life experiences. LOC is measured using the Internal-External (I-E) scale (Rotter, 1966).

There have been three configurations of LOC that have been considered in this field; attributed to Rotter, Collins, and Levenson. Collins (1974, p.381) carried out a factor analysis of the Rotter (1966) I-E scale and produced four distinguishable subscales for the external items. It was concluded that "a respondent may score external on the Rotter I-E scale because he believes: the world is difficult, the world is unjust, the world is governed by luck, or the world is politically unresponsive". This shows that the differences within external individuals are probably as great as the differences between internal and external individuals. Levenson (1974) developed the 3 dimensional scale of LOC - again focusing on the external category suggesting two influential parts - and divided behaviour into that which is internally controlled, controlled by powerful others, and controlled by chance. The latter three factor model is most widely used and will be discussed in more detail in the following section on health locus of control.

LOC has been used as a predictor of behaviour based on the assessment of LOC orientation. However, it would not appear to be that simple. As Wallston & Wallston (1981, p.222) point out, "social learning theory (Rotter 1954; Rotter *et al.* 1972) states that generalised expectancies (such as LOC orientation) are particularly predictive in novel situations but, as the person gains experience in specific situations, the predictive power of generalised expectancies decreases and is supplanted by situation-specific expectancies". Thus the influence on behaviour of previous life experiences, be they negative or positive, are not to be undervalued - as will be seen in the section on negative life events.

Depression is thought to be linked to learned helplessness (Seligman, 1975), the tendency to blame failure on others or on the situation but never on oneself. If extrapolated in the context of Internal-External locus of control dimensions (Rotter, 1966), this indicates a high degree of external beliefs. Lefcourt (1982, p.110) points out that "It is obvious... that locus of control does play some role in affecting the ways in which people cope with their experiences. However, that role is complex, interacting as it does with other variables such as time of life stress, social support, and no doubt other variables as well".

Conversely, internal LOC (ILOC) has been linked with various constructs in turn associated with feelings of well-being such as help-seeking behaviour. Raja *et al.* (1994, p.213) established that not only was "a pure ILOC strongly associated with the report of good health [but also that] women with a strong belief in I and PLOC were significantly more likely to have received treatment for their depression compared with other groups".

Very little research was carried out using LOC as a predictive factor prior to the development of the health locus of control scales (HLOC). Two studies using LOC were: Hayworth *et al.* (1980) and Little *et al.* (1981). Hayworth *et al.* (1980, p.161) suggested that "women who perceived themselves as less in control of their lives (antenatally) were likely to rate high on depression postnatally, as were younger women" in a sample of multigravidas and primagravidas with the Rotter (1966) I-E scale. Little *et al.* (1981, p.385) postulated that "PND was associated with high ante-natal scores on either overall hostility and extrapunitiveness or ELOC ratings and intrapunitiveness". Dimitrovsky *et al.* (1987) used Rotter's (1966) LOC and the Zung self-rating depression scale and found that "external LOC showed a low but significant correlation with prepartum depression but was not predictive of postpartum depression." (p.235). The development and implementation of more specific health-related locus of control scales thus commenced around this time.

1.3.1.1 Health Locus of Control

Development of the concept of HLOC began when Wallston *et al.* (1976) devised a unidimensional bipolar scale (internal-external) called the Health Locus of Control scale (HLC). They attempted to relate it to health value (HV), and intended information seeking. They concluded that HLOC interacted with HV to predict intended health related behaviour.

Wallston & Wallston (1981) report the work of Bloom (1979) who compared the HLC scale scores of two groups of mastectomy patients within one week and at two months postsurgery. One half of the sample received a special counselling intervention, while the remaining half received only standard care. There were no between groups differences at the first contact point, but the intervention group was significantly less external than the comparison group at the second point of contact. "However, this was evident only on the 6-item Fate subscale that Bloom derived from an earlier factor analysis of a larger group of mastectomy patients" (p.213). Bloom (1979, p.638) concluded that "the effect of the intervention was to cancel out what would have been a more fatalistic attitude on the part of the treatment group subjects". Thus increased health-promoting

activity would seem to make individuals more likely to believe that they control their health as oppose to powerful others or chance.

Wallston *et al.* later went on to develop the Multidimensional Health Locus of Control scale (MHLC) in 1978 which was influenced by the work of Levenson (1974) three factor model and consisted of tridimensional unipolar scales recognising the need to differentiate within the external control concept. The three factors were internal (IHLC), and from the external control concept; powerful others (PHLC), and chance (CHLC).

DeVito *et al.* (1982) replicated Wallston *et al.*'s (1976) research into Health LOC, health value, and intended information seeking (requesting/selecting pamphlets) - they also investigated *actual* information seeking. They found support for Wallston *et al.*'s work on intended behaviour but this did not extend into actual health-related information seeking. It was concluded that "the weak relationship found between actual and intended information seeking calls into question studies using intent measures as if they were almost identical to actual behaviour " (p.63).

Muhlenkamp *et al.* (1985, p.331) study of actual behaviour using the MHLC provided support for DeVito *et al.* (1982) suggesting that the lack of predictive power of the MHLC may be due to the weak relationship between intent and actual behaviour. This supports the conclusions drawn in section 1.2.1 regarding the unreliability of models designed to predict intentional health-related behaviour for predicting actual health-related behaviour.

1.3.1.2 Health Locus of Control & Health Behaviour

One of the earliest studies was carried out by Seeman & Seeman (1983) who studied three domains of health behaviour: preventive care, health knowledge and perspectives, and physical status, for example, acute and chronic illness. They concluded "a sense of low control is shown to be significantly associated with less self-initiated preventive care; less optimism concerning the efficacy of early treatment; poorer self-rated health; and more illness episodes, more bed confinement, and greater dependence upon the physician" (p.144). This work was supported by Brown *et al.* (1983, p.328) who found that "individuals who believed they had little personal control over their health were found to engage in the least amount of health promotion activity". They go on to say "it makes sense that individuals who believe they have little personal control over their health would have little reason to engage in positive health practices" (p.331).

Muhlenkamp *et al.* (1985) categorised the type of health care clients had requested at a community clinic for the previous two years. These were: health promotion, illness prevention, health maintenance and health restoration. They made three main inferences: "health value was not

related to self-reported health promotion activities or to types of clinic visits; a strong belief in chance was negatively associated with engaging in health promotion activities; and a strong belief in powerful others was negatively associated with a high percentage of restoration visits" (p.327). The relationship between health value and engagement in health promoting activities has been refuted time and again (for example, Brown *et al.*, 1983; McCusker & Morrow, 1979; McKillip & Vierke, 1980; Zornow *et al.*, 1981), and so was not studied here.

Frauman & Nettles-Carlson (1991) study of well adult clients in a nursing practice found the best predictors of a health promoting life-style were: conception of health as exuberant well-being (rather than absence of disease) and college education. The investigators concluded that "Pender's postulated relationship between perceived control of health and engaging in health-promoting behaviours was supported in this study. Other researchers, including Muhlenkamp *et al.* (1985), Speake *et al.* (1989), and Pender *et al.* (1988), have also found a relationship between health locus of control and a healthy life-style" (p.178). It was reported by Kelly (1995) that "numerous studies have demonstrated that along with internal LOC, powerful other LOC scores also positively relate to preventive health practices (Cwikel *et al.*, 1988; Labs & Wurtele, 1986; Wallston & Wallston, 1982)" (p.107). Therefore locus of control has been shown to indicate an individuals participation in preventive health practices which will be explored further in the present study with respect to an antenatal intervention.

1.3.1.3 Fetal Health Locus of Control & Health Behaviour

The FHLC scale of Labs & Wurtele (1986) was reviewed by Furnham & Steele (1993) in their critique of locus of control questionnaires. They describe it as aiming: "to apply Levenson's three-factor model, successfully applied by Wallston *et al.* (1978), to the specific domain of beliefs concerning fetal health. Internal consistencies for the three subscales of internality, chance and powerful others were good; satisfactory concurrent validity with the MHLC (Multidimensional Health Locus of Control Scale; Wallston *et al.*, 1978) was reported; social desirability was controlled for; and predictive validity in terms of women's (N=63) beliefs and behaviours during pregnancy yielded interesting findings (Labs & Wurtele, 1986). For example FHLC-I (internal) scores predicted smoking status and the *intention* to participate in childbirth classes" (Furnham & Steele, 1993, p.460, my italics).

Actual attendance was not measured and the results were reported in terms of intenders and non-intenders. The present study is designed to take this implication one step forward, by investigating the *actual* rather than *intended* health information seeking behaviour patterns which

have already been shown to be weakly related (see sections 1.3.1 and 1.4.2). Labs & Wurtele (1986, p.818) concluded that "there is preliminary evidence that the FHLC may be clinically useful in the care and education of the obstetric patient. The FHLC, requiring only 10-15 min to complete, may be helpful in identifying 'high-risk' patients early in their pregnancy, specifically, those patients who do not have strong beliefs concerning their personal role in determining the health of their unborn children".

Spirito *et al.* (1990, p.195) compared the FHLC and the Maternal HLC and their "findings suggest that when providing care for pregnant women with diabetes, clinicians might best emphasise the effects of maternal behaviour on the health of the fetus rather than on the mother's own health". Tinsley *et al.* (1993, p.98) also support the notion of specificity of measures to the area of behaviour under investigation and state that "the success of this study [Labs & Wurtele 1986], in contrast to the investigations by Faragalla (1983) and Desmond *et al.* (1987), was most likely due to the specificity achieved with a scale measuring women's fetal health control as opposed to the control of their *own* health".

In a study using the FHLC to investigate the relationship between health locus of control and variables such as the number of previous elective abortions and the duration of the present pregnancy, Bielawska-Batorowicz (1993) found these variables to be predictive of FHLC subscale scores. She reported that duration of the present pregnancy was positively predictive of the chance subscale score and the number of elective abortions in the past was positively predictive of the powerful others sub scale. In relation to other health issues Stewart & Streiner (1995) concluded that smokers were more likely than non-smokers, using the FHLC, to believe 'chance' influenced the health of their fetuses as oppose to their fetuses health being controlled by themselves (internal) or powerful others.

A review of the evidence cited here with respect to health-promoting behaviour suggests that individuals who have high internal and/or powerful others locus of control would be more likely to come to the intervention. However, individuals who are low in mood, and thus will be invited to come to the intervention, have high external (chance) locus of control and so will be less likely to engage in health protective behaviours. Thus the impact LOC has on engagement will be investigated in the present study.

1.3.2 Psychosocial Support

Psychosocial support has been defined as “an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient” (Shumaker & Brownell, 1984, p.13). The emphasis on the exchange of resources between two individuals, and the perception of that exchange, was an important development in this area of research. The result was that the myriad of combinations of supportive human relationships has been studied in detail to give a more accurate reflection of supportive interactions.

Various types of psychosocial support have been identified and categorised. However, Power *et al.* (1988) suggest that the general categories of emotional and practical support are sufficient to assess the quality of a persons' significant relationships. Emotional support can be defined as all those instances where reassurance, intimacy and the knowledge that one is loved and cared for are received, when advice is either sought from, or offered by, someone who can be confided in and relied upon to help. Practical support covers all aspects of help that involves aiding an individual with a problem in a physical or ‘doing’ capacity, for example, lending money or helping to carry out tasks that the individual is unable to do by themselves.

The sources of psychosocial support that have the greatest influence on an individual are the people closest to them, collectively known as that person’s “significant others”. Psychosocial support may be *available* in different amounts from different sources and some sources may be more *acceptable* to the individual regardless of whether the support was either sought or offered.

All the possible sources of social support that individuals have available to them can be collectively referred to as their ‘social network’. A person's social network can be broken down into primary and secondary sources. Primary sources include partners, close relatives, good friends, and, with reference to pregnancy, may include health professionals such as the woman’s general practitioner, her midwife, or her obstetrician. Secondary sources include, for example, friends and relatives who are not so close, acquaintances and perhaps work colleagues. Which individual in their social network a person turns to or gains support from will depend on that person's perception of not only the availability of support, but also the acceptability of support from that particular source. It will also depend upon the particular type of support that is sought. The person's perception of the combination of availability and acceptability is likely to be built on from previous experience of problems or difficulties.

Psychosocial support is thought to protect against, or at least lessen, the negative effects of psychosocial risk factors. Culpepper & Jack (1993) divided psychosocial risk factors into three categories. The first was demographic or social characteristics, such as being young or old, poorly educated or living in inadequate housing. The second category was psychological factors like stress and/or anxiety and previous or ongoing psychiatric problems. The final category was adverse health habits, such as smoking, drinking, drug abuse, and being over/under-weight. This section will focus upon the psychological factors, in particular, the area of poor social support and its interaction with stress/anxiety.

1.3.2.1 Psychosocial Support & Health Behaviour

Downe (1997) reported that a potentially problematic effect of excessive support from a health professional is that it could increase the likelihood of dependency on that source/person for future help. This was succinctly reported as “If we [as midwives] are intensively involved in a woman's care, she will probably feel happy, and extremely grateful to us - and, when she finishes seeing us, she may well feel bereft” (p.43). She goes on to suggest that to protect against this the women should be taught “how to tap into support systems”. Therefore, improved health promotion networks within primary care professionals and improved health promotion information for the women receiving the care could increase the selection of appropriate health service usage. This in turn would increase the likelihood that an individual's needs are being effectively met. Knowledge of appropriate support systems is a health-promoting factor applicable in all areas of our lives and is a core element of the antenatal psychosocial intervention used in this study.

1.3.2.2 Psychosocial Support & Depression

There are two general explanations of how psychosocial support reduces stress and ultimately protects one's mental health from, for example, anxiety or depression. The *Main or Direct Effect* model suggests that psychosocial support is a protective factor in all situations, not just during periods of perceived stress. The current school of thought tends to favour the *Buffering* hypothesis. This theory proposes that psychosocial support buffers individuals from stressful events as and when they occur. That is support is only functional in its protective role when stress is experienced and not as an ongoing barrier to stress as in the Main or Direct Effect model, (Cohen & Wills, 1985; Champion & Goodall, 1994).

A possible explanation for the lack of consensus of opinion in accounting for the way that social support is utilised by one or other of these theories is psychosocial factor differences among the

samples used in previous research. With locus of control, for example, Sandler & Lakey (1982, p.65) found that "locus of control did affect the receipt and impact of social support. Externality was positively related to the quantity of support received but the stress-buffering effect of support was obtained for internals and not externals". Lefcourt *et al.* (1984, p.387) corroborated the findings of Sandler & Lakey (1982) and differentiated between the two loci as follows, "internals express less need of but show better effects from having social support than do externals who show more need of but obtain fewer benefits from social support." Therefore, when investigating the impact of social support, locus of control (amongst other factors) should be controlled for between participants in the treatment and control conditions to enable conclusions to be confidently drawn.

1.3.2.3 Psychosocial Support & Postnatal Depression

It is a widely held opinion among health professionals that psychosocial support has a positive influence upon mental health throughout the life span of an individual. During pregnancy its presence has been shown to significantly enhance the woman's emotional well-being.

Poor social support, in particular the lack of a warm confiding relationship with her partner, and/or with her own parents, has been identified in numerous studies as a factor associated with postnatal depression (Oakley, 1992; Elliott, 1989; Ball, 1987). A lack of adequate social support (as perceived by the individual using her own terms of availability and acceptability) from significant others such as her partner, parents, best friend(s), and professional care-givers, has been found to correlate with low emotional well-being (Oakley, 1992).

Although the idea that a lack of adequate social support has negative consequences has been extensively (but not exhaustively) researched, it may not provide an account of some women's postnatal depression or postpartum low level of emotional well-being. The possibility has been suggested that *too much* social support can be equally problematic as *too little* (Downe, 1997). This is beginning to be investigated. For example, a study called 'Partners in Parenthood: who needs them?' (carried out in 1996 by the author and reported in Wheatley (1998) with a group of 48 first-, second- and third-time mothers randomly drawn from the general population, found that women who reported receiving *a great deal* of emotional and practical support from their partners during pregnancy were significantly more likely to experience *low* levels of emotional well-being postnatally. It was concluded that the levels of practical and emotional support the women received antenatally from their partners may well have accumulated disproportionately and beyond their possible reciprocation. This may arguably have resulted in additional stress, guilt, and the

development of symptoms of postnatal depression. However, the study requires rigorous re-investigation employing a larger sample, to ascertain just how influential this caring deficit may be and how, in practice, this negative effect can be reduced, particularly since the conclusions drawn were speculative with respect to the effect of partners. Nonetheless, the explanation offered makes intuitive sense to many, including Welford (1998), and should not be entirely discarded as an avenue of future research.

To summarise the discussion of this factor of health-promotion behaviour, individuals with poor psychosocial support are less likely to engage in an intervention due to the frequently cited probability of them also having low mood. However, attending an intervention designed to promote psychosocial support, such as the intervention in this study, should reduce the risk of future low mood, i.e. postnatal depression. It has thus been planned to explore the impact poor psychosocial support has in individuals identified as currently experiencing low mood on their engagement to a health-promoting intervention.

1.3.3 Negative Life Events

The foundation of life-events research can be traced to the experimental work of Cannon (1927). Interest in the measurement of stressful life events developed in the 1960's and 1970's, for example, Holmes & Rahe (1967) and Dohrenwend (1973). Interest in the relationship of life stress to depression increased with the work of Brown in the mid to late 1970's who focused on meaning in the measurement of life events. It was acknowledged that different individuals may perceive the same life event as more or less stressful depending upon the combination of their life circumstances and personality. This development in the empirical study of life events stimulated a variety of research. The research discussed in this section is again that conducted mainly with respect to women.

1.3.3.1 Negative life events & Health Behaviour

Life events have been found to have significant effects in many contexts. For example, Solomon (1989, p.111) assessed the "factors that interfere with psychiatric help-seeking among soldiers suffering from PTSD". It was found that individuals who sought help differed from individuals who did not do so in terms of their greater symptom severity, lower self-efficacy and their experience of *fewer* negative life events. This latter finding is puzzling since much previous research has indicated that individuals who seek help have experienced a *greater* number of

negative life events (Brown & Harris, 1978). Solomon goes on to suggest that “a high magnitude of prior negative life events may induce stress inoculation, making PTSD casualties feel that if they were able to endure so many difficulties before, they can also endure their PTSD now. According to this interpretation, a large number of negative life events would work in tandem with low symptom severity in making treatment seem unnecessary” (p.120).

In Weinstein (1987, p.481) study of optimistic bias about susceptibility to harm it was found that extrapolating past experiences to estimate future vulnerability to harm decreased the likelihood of optimistic bias being exhibited as the individuals' perceived frequency and actual previous experience of the situation or event increased. This would seem to lead to a distorted optimistic bias, not a realistic bias, similarly seen by Byrne & MacLeod (1997) in anxious and depressed participants when they were asked to rate the likelihood of them experiencing negative or positive events in the future.

With respect to locus of control, Sandler & Lakey (1982) investigated the effects of LOC beliefs as an individual difference variable on the relationship between negative life events and psychological disorder, perceptions of control over negative life events, and the receipt and impact of social support. They reported that (1) the correlation between negative events and anxiety was greater for externals than for internals; (2) the correlation between negative life events and depression was greater for externals than for internals; (3) LOC was not correlated with ratings of control over negative events; (4) there was no correlation between high control negative events and psychological disorder; and (5) there was no correlation between low control negative events and psychological disorder. Resolution of a life event or crisis was found to influence LOC in Smith's (1970) study which "hypothesised that crisis patients, overwhelmed by external forces in their lives, would initially be more externally oriented on the I-E scale than a similar group of noncrisis outpatients, but would show a significant shift toward the internal end of the dimension following a 6 week crisis resolution period" (p.329). This hypothesis was supported.

1.3.3.2 Negative life events & Depression

Brown & Harris (1978) found that 89% of the women in their study who became depressed had had a severe life event or major life difficulty compared with 30% of the women who did not become depressed. In addition, four particular vulnerability factors put these women at more risk of depression when faced with a stressor. These four factors were: absence of a close and confiding relationship with a partner, lack of outside employment, loss of mother before the age of 11 years, and the presence of three or more children under the age of 14 in the home. It is thought

that the first of these vulnerability factors is the most likely to act as a catalyst for depression when a negative life event occurs.

1.3.3.3 Negative life events & Pregnancy

Shereshefsky & Yarrow (1974), amongst others, cite that many studies have shown that a lack of a close confiding relationship with a partner has a negative effect on adaptation to pregnancy and the maternal role. This vulnerability factor may have interacted with a life event in the course of the pregnancy to produce this effect. Alternatively, it could be argued that a poor marital relationship may be a life event in itself. Such issues need further study and are at best speculative at this point.

More recently, Bielawska-Batorowicz (1993, p.103) found that the number of previous elective abortions (a stressful life event) and the gestational stage of the present pregnancy were found to be predictive of women's fetal health locus of control (FHLC) score. She accounted for this finding by arguing that (as LOC theory proposes) previous experience with certain types of relevant situations can modify a person's internal vs. external expectancies (Rotter, 1975). It is possible that a woman's previous obstetric history could alter her LOC beliefs over the health of her unborn child. Indeed, lifestyle changes during pregnancy have been found to be associated with previous miscarriage (Bielawska-Batorowicz, 1990) and high internal FHLC scores (Labs & Wurtele, 1986). It was suggested those women who had an elective abortion in the past "had exercised real control over their fetus [and as such] might feel more responsible for their unborn children's well-being and thus score higher on the I sub-scale". In fact, it was predictive of a higher score on the P sub-scale. This was explained by assuming that although the woman had made the decision to have an abortion, it was actually carried out by a health professional. This is an illustration of a situation in which a woman's own meaning and perception of the life event differs from that which was anticipated based on the empirical evidence available.

Women who had experienced, or were experiencing, abuse (a life event) were investigated by Stewart & Cecutti (1993), who found these women believed they had little internal control over the health of their fetuses and that fate played the most important role in the outcome of their pregnancy. It would not be possible to tease out the direction of cause and effect in this finding but it would be interesting to explore in the future.

Therefore, the full life situation, i.e. the recent life events, of the women taking part in any study should be established to enable identification of any possible confounding variables. An acceptable time period for the definition of 'recent' was suggested by Barnett *et al.* (1983, p.319) to be the

"period of 12 months immediately prior to the completion of the scale [or interview], a time period within which reporting of events may reasonably be expected to be reliable".

1.3.3.3 Negative life events & Postnatal Depression

One of the earliest studies to report on the impact of negative life events, Paykel *et al.* (1980) found that the most influential factor in PND was the occurrence of recent stressful life events. Molfese *et al.* (1987) explored the impact of stress as influenced by the effects of psychological and social variables on perinatal outcomes. It was seen that life event stress is influenced by social support, pregnancy attitudes and LOC at this time. This study examines the inter-relation of locus of control, social support and negative life events.

Thus in precis it would seem that this psychosocial risk factor would appear to be potentially influential in the engagement of women to a health promoting intervention. As the measure of negative life events used in this study includes items relating to pregnancy, it is planned to not only establish whether a greater or lesser number of recently experienced life events make an individual more likely to seek help in the form of the intervention, but also whether pregnancy specific events are more predictive than the non-pregnancy specific events. It is hoped that this may clarify the predictive ability of this influencing factor in connection with their assessment of need for health-related information and therefore, their engagement in the antenatal psychosocial intervention.

1.4 Rationale for Current Research

1.4.1 Concluding remarks of earlier researchers

Wallston *et al.* (1983, p.383) concluded that "this study suggests that individuals expectations about control over their health are related to their preferences for control over their health care. Understanding individual preference is an important part of understanding behaviour and is necessary for planning means of increasing preventive health behaviours and compliance".

Labs & Wurtele (1986, p.818) reported that "It is anticipated that tailoring patient education programs to the mother's LOC orientation (cf. Best & Steffy, 1975) should enhance the woman's adoption of healthy maternal behaviours. For example, fetal health 'internals' could be encouraged to participate in the management of their prenatal regimen, whereas women endorsing the 'powerful others' dimension may be more amenable to a more direct, didactic approach from their physician. Matching patient health expectancies to a specific prenatal care approach could significantly improve both maternal and fetal health".

York *et al.* (1993, p.241) suggested that "Data that expand knowledge on why women receive inadequate prenatal care will be useful in developing community outreach programs, preparing public service announcements, and designing prenatal services".

1.4.2 Rationale

As these concluding comments by researchers working in this topic area illustrate there is a great need for clarification, not only of how health workers can improve the general population's experiences of pregnancy and the postnatal period, but why so many women seem to be unreachable at this time. It is possible that this 'unreachable' group of women may include those most vulnerable to PND (Davison & Neale, 1990). It became apparent that the issue of engagement warranted further investigation after the pilot study stage of the RCT trial (which examined the efficacy of the intervention with respect to the prevention of postnatal depression) had been completed. It was then that the bud of this thesis began to form in my mind.

It is hoped that the present study will expand knowledge regarding the engagement techniques used for a health-promoting intervention and provide empirically supported guidelines to maximise participation in future interventions, thereby maximising the likelihood of achieving the aims of the reduction and prevention of PND.

1.4.3 The Present Study: Aims and hypotheses

Aim: The study will investigate engagement via the individual trait characteristics and psychosocial risk factors that may influence participation in an antenatal psychosocial intervention designed to reduce postnatal depression, run within the current maternity system.

Hypotheses:

- Engagement in the intervention will *increase* due to the presence of a combination of an antenatal trait characteristic that has been found to influence health-promoting behaviour: high internal locus of control, high powerful others locus of control, and low chance locus of control.
- Engagement in the intervention will *decrease* due to the presence of poor psychosocial support in individuals currently experiencing low antenatal mood which has been found, in combination, to influence health-promoting behaviour.

- Engagement in the intervention will *decrease* due to the recent experience of negative life events, and in particular, with the recent experience of negative life events that are contextually relevant i.e. pregnancy related, which has previously been found to influence health-promoting behaviour.

These will be investigated using quantitative methods in the first study. A second exploratory study, using qualitative methods, will be carried out that will produce data comprising the experiences of the participant's with which the findings of the quantitative study can be compared and contrasted, and which may complement the findings of the quantitative study.

2. Quantitative Study Methods

In order to report the first study I shall describe how the intervention was presented to the women attending the antenatal clinics, and the procedures followed to encourage the women to initially engage in the study. The baseline assessment stage will be outlined. Particular emphasis will be given to the information given to the participants to enhance the likelihood that they would want to be randomised with the opportunity of being invited to attend the intervention itself. I shall then describe a novel intervention designed to prevent PND. The attempts that were made in the pilot study to enhance engagement at the intervention stage will be described. Finally, the procedures followed for the postnatal outcome assessments of measures of engagement are detailed.

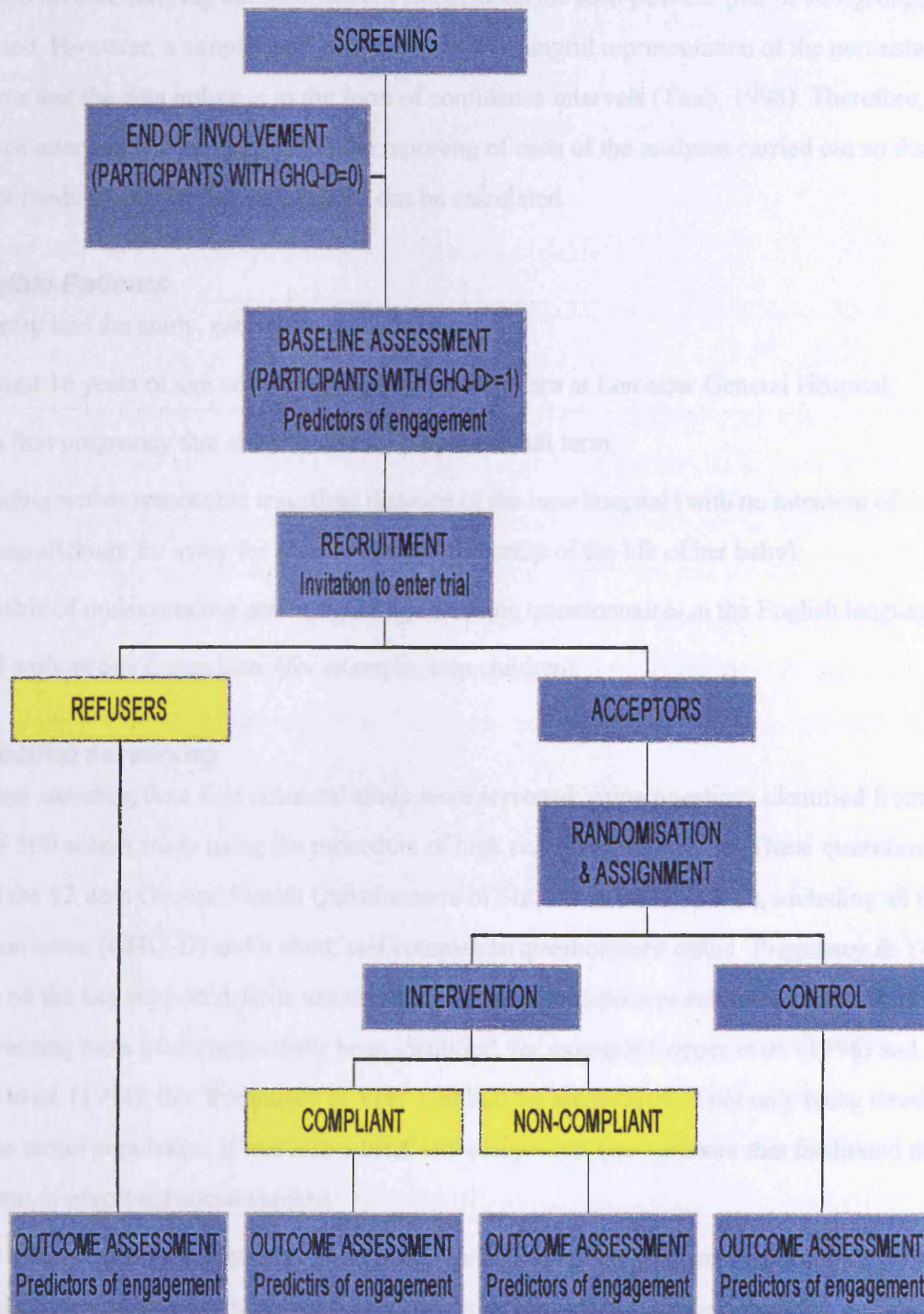
Both the quantitative and qualitative studies of this thesis were carried out with patients from the Leicester General Hospital. It is one of two major hospitals in a district serving a population of at least 900,000 people (Leicester District Health Authority, 1987). Every attempt was made to ensure that the population sampled was representative of the general population to maximise the generalisability of the results.

2.1 Design

The design of the quantitative study was a prospective observational study nested within a randomised controlled trial. The RCT itself explored the efficacy of an intervention in relation to the prevention of postnatal depression. Young mothers in their first pregnancy, identified by screening to be at high risk of postnatal psychiatric depressive disorder, were recruited and then randomised to receive either a brief focused intervention designed to reduce deficits in social support, or standard antenatal care. The engagement of participants at the recruitment and intervention stages of the quantitative study was explored and compared. See figure 2.1, the quantitative study design chart, to illustrate the stages in the study at which the three engagement sub-groups of the participants was to be examined.

Ethical approval was obtained from Leicestershire Health Authority for the trial above in July of 1994 (ref. 3533).

FIGURE 2.1 QUANTITATIVE STUDY DESIGN



2.2 Study power

The value of calculating the power of the results from this study was considered. However, straightforward power calculations are calculated between two groups and this study explores the engagement of the participants across three sub-groups (compliant, non-compliant, and refusers). This would involve carrying out independent calculations for each possible pair of sub-groups to be analysed. However, a simpler and perhaps more meaningful representation of the percentage of confidence that the data imbue is in the form of confidence intervals (Taub, 1998). Therefore, confidence intervals will be included in the reporting of each of the analyses carried out so that the margin of random error of the odds ratio's can be calculated.

2.3 Eligible Patients

For entry into the study, each woman had to be:

1. at least 16 years of age when booking for obstetric care at Leicester General Hospital;
2. in a first pregnancy that she planned to continue to full term;
3. residing within reasonable travelling distance of the base hospital (with no intention of moving significantly far away for at least the first 3 months of the life of her baby);
4. capable of understanding and completing screening questionnaires in the English language;
5. and without any dependants (for example, step children).

2.4 Selection screening

Women attending their first antenatal clinic were screened, using questions identified from the Leicester 500 cohort study using the procedure of high risk group modelling. These questions included the 12 item General Health Questionnaire of Surtees & Miller (1990), including all the 6 depression items (GHQ-D) and a short, self completion questionnaire called 'Pregnancy & You', focusing on the key support deficits identified in the earlier prospective cohort research. Whilst other screening tools have successfully been identified, for example Cooper *et al.* (1996) and Appleby *et al.* (1994), the 'Pregnancy & You' tool had the advantages of not only being developed within the target population, it was also a brief self-completion questionnaire that facilitated the assessment of perceived social support.

As in the previous Leicester 500 cohort study carried out in the same antenatal clinic, it was predicted that it was possible to screen 800-1000 women in a one year period with a negligible

refusal rate (Brugha *et al.*, 1998a). It was predicted that 15-20% would be identified as being at high risk, consenting and eligible for inclusion in the randomised controlled trial.

Via antenatal medical records women were identified as primagravidas at their first appointment at clinic when they were between 12 and 20 weeks gestation. The RA (JS) approached the women personally after they had reported to reception and explained to them the nature and purpose of the work. They were invited to complete the questionnaire preferably during the clinic, and/or while waiting between ultrasound scan and consultant appointments. In the event of their having insufficient time to fill in the questionnaire during the clinic they were given a freepost envelope to return it to the team at Leicester General Hospital.

2.4.1 Consent at Screening

The patient information on the screening form was as follows:

“We are a research team made up of health professionals from Leicester General Hospital and the University of Leicester and we would like you permission to help us with a general health study. We are interested in the stresses and strains involved of becoming a parent for the first time and wish to learn from you in order that we may keep improving our service to expectant mothers.

We are asking all women who are expecting their first child and who are booked-in for their antenatal care at the Leicester General Hospital to participate. To take part we ask you to fill in a questionnaire. The emphasis of this study is you and your pregnancy so please complete it individually. All the information you give us will be treated as strictly confidential. With your help we hope to get a better idea of the sort of extra support health professionals could best provide for pregnant women to maximise their well-being.

Some of those who complete the questionnaire will be invited to help us more with a further part of the study. Again your participation with a further part of the study will be purely voluntary. We very much hope that everyone we ask can take part as the more women we study the better.”

This information was detached from the questionnaire and kept by the participant. The nature and purpose of the work was explained and only those willing to participate (i.e. who gave informed consent) were involved further. Women who preferred not to complete the questionnaire were informed that this would not affect their care and that their midwife and doctor would remain unaware that they had chosen not to participate.

2.4.2 Enhancing engagement at screening

The majority of women (approximately 95%) were pleased to help, and returned the questionnaire promptly. However, for the minority, a reminder system was operated that followed a set procedure. The women were telephoned to ask if they had any queries about the 'Pregnancy & You' questionnaire and gently reminded that their answers were very important to the study. If they were uncontactable by telephone a letter was sent. Most women then posted the questionnaire back within a week; a few had decided not to complete it and declined to take any further part in the study.

2.4.3 Selection at screening

Once the questionnaires were returned, they were allocated a participant number, and scored for GHQ-D and SS. The 'top sheet' containing all demographic information i.e. name, address, and telephone numbers of the participant, was removed and stored separately from the now anonymised questionnaire data. The data from those individuals identified as 'screen positive' (at increased risk of developing postnatal depression, $\text{GHQ-D} \geq 1$) were passed on to the RA for contacting at the baseline assessment stage. Data on all the women who were not identified as depressed (i.e. questionnaires that were scored $\text{GHQ-D}=0$) were stored separately.

2.5 Baseline Assessment

To avoid the eventuality that a woman might be contacted for baseline assessment who was no longer pregnant, a system was set up with the antenatal medical record team to notify the RA (SLW) if this occurred. To ease identification, all women who had accepted a screening questionnaire had a small sticker placed in their hospital obstetric notes indicating that they were a member of the research sample.

2.5.1 Selection for Baseline Assessment

Women who were screen positive and who gave informed consent for participation in the project were selected to undergo a detailed interview carried out by the RA, covering clinical and psychosocial variables some of which were used in the previous study (Brugha *et al.*, 1998). Assessments were coded directly into a laptop computer. Participants were asked to agree to a later postnatal outcome assessment and to provide, in addition to their own current home address, two other addresses and telephone numbers through which they could be contacted later if necessary.

2.5.2 Arranging the Baseline Assessment

All selected women were contacted by telephone 4 weeks after screening in estimated delivery date month batches. The RA (SLW) introduced herself as working for the 'Preparing for Parenthood' study and thanked them for completing and returning their Pregnancy & You questionnaires. They were then told that they had been chosen to have a home visit, and a mutually convenient appointment time was made. If the woman was uncontactable by telephone, a letter was sent suggesting a date and time for the home visit.

2.5.3 Enhancing engagement at Baseline Assessment

The majority of women were at home for their appointments. However, if a woman was not at home (after a wait of approximately 10 minutes) a "Sorry I missed you" note was left saying that the research team hoped she was well and asking her to telephone the LGH to rearrange the appointment or let the team know if she no longer wished to carry on helping us in our work. After two rearranged appointments, when the woman was not home, a system operated such that a letter was sent expressing regret that the time has now passed "when we could have met for a chat" and thanking her for her involvement in the research.

2.5.4 Consent at Baseline Assessment

The standard participant information for the baseline assessment is shown below.

"We are evaluating a new additional service for expectant mothers and we feel that you are the kind of individual that we would be interested in. In order to evaluate this new service, the "Preparing for Parenthood" course, we must compare it with the existing antenatal maternity care service. However, we do only have a limited amount of resources and so can only offer this new additional service to a select few at this time. We decide which ladies will be participating in this course by choosing them at random, rather like tossing a coin. So, you will have an equal chance of being chosen for or not chosen for the Preparing for Parenthood course. If you are chosen to participate in the new service, it would not be instead of the standard parentcraft classes. We would expect you to go ahead with any plans you have made to attend parentcraft classes. We do hope that you will agree to continue to help with our work; if, however, you decide you do not wish to continue with our work you may say so at any time as your participation is completely voluntary."

This was read out to the participant. Upon the participant's agreement to consent the baseline assessment was then carried out in a pre-established order of component questionnaires and interviews.

2.5.5 Measures used at Baseline Assessment

The interview was carried out in the following order, the measures of health-promoting behaviour investigated in this study being marked with an asterisk: pre-consent questionnaire, demographic details, General Health Questionnaire (GHQ; Surtees & Miller, 1990), Leicester Housing Schedule (Wheatley, 1998), Service Contact questionnaire (based on work by the ONS; Meltzer *et al.*, 1995), Interview Measure of Social Relationships *(IMSR; Brugha *et al.*, 1987), Obstetric & General Life Events questionnaire *(adapted from Barnett *et al.*, 1983), Fetal Health Locus of Control scale *(FHLC; Labs & Wurtele, 1986), General Difficulties questionnaire (based on work by the ONS; Meltzer *et al.*, 1995), Problem Solving Inventory (PSI; Heppner & Petersen 1982), Antenatal Social Support questionnaire *(derived from the screening questionnaire; Brugha *et al.*, 1998), and the Edinburgh Postnatal Depression Scale (EPDS; Cox *et al.*, 1987).

The standardised order of the completion of the measures was selected randomly apart from the pre-consent questionnaire, which was designed to identify any woman who should be excluded from the research and as such was completed first. This information was not gathered earlier at screening due to its sensitive nature and its inappropriateness to the majority of participants. If a woman did fall into any of the exclusion categories she was thanked for her help in our work and the baseline assessment was terminated by the RA. This happened in 11 cases: 2 women already had one child, 1 woman was responsible for step-children on a full time basis, and 8 women did not have a standard of English sufficient to communicate within an intervention group.

2.6 Recruitment to the Intervention

When the information gathering section of the baseline assessment was completed, the RA went on to outline the next stage of the study; that is, the opportunity to be invited to attend the intervention. The information leaflet for the intervention was as follows:

“The aim of this course is to help make becoming a parent easier and more enjoyable. It will provide the chance to talk about the concerns that are bound to go with this ‘new job’, and help you find ways of reducing the stresses and strains, both now and in the future. The focus is on the practical and emotional aspects of parenthood, and taking care of yourself in the broadest sense.

Currently, about 1 in 10 women experience postnatal depression in the weeks and months following birth. This course is designed to reduce the chances of this occurring.

We have found that it is helpful to have a combination of a structured input, free discussion and exercises to do at home. The topics and timetable of meetings is outlined on the next page [see section 2.7.5]. You will be encouraged to relate topics to your own life situation, and to raise issues that particularly interest you. However, in order to cover a wide range of helpful topics, we will keep more or less to the timetable.

Pre-course [initial] meeting. The course leaders will meet with you to discuss the course, and to begin to get to know you. They can answer your questions and together you can discuss how the course could help you. Your partner, or someone close to you, is welcome to come to this meeting, which will usually be in the parentcraft room.

Handouts will be given out at the end of each session, summarising the main points and providing further information. You will also have the chance to build up a personal file for you to keep and look at, long after the course has finished.”

This was read to the participant and the leaflet was given to them to keep. Any questions that she may have had were answered. The majority of baseline assessments were carried out with only the participant and the RA present. On the few occasions where others were present, these were usually the woman’s partner, her mother or her mother-in-law.

2.6.1 Randomisation

All women had access to the hospital's routine antenatal health education programme and counselling on request or when clinically indicated. Stratified randomisation was used to allocate half of the women to intervention and half to the control group. Randomisation was carried out using the computerised minimisation program (MINIM; Evans *et al.*, 1990). The control women were not contacted further by the research team until a postnatal outcome assessment.

The three stratification variables were: degree of vulnerability to PND through antenatal GHQ-D score (high = 3+, low = 1 - 2); level of antenatal social support (high = 6, low = 1 - 5); and ethnicity (European or Asian).

2.6.2 Assignment Procedure

Upon contacting the participant by telephone 24-48 hours later to obtain her decision regarding the randomisation, a standard procedure was followed. If she had decided that she would not like to take up the opportunity of attending PFP, she was then told that we would like to contact her

again when her baby was 3 months old. These participants are referred to as 'refusers' - they declined the intervention but expressed an interest in future follow-ups.

If she indicated that she would like to accept the invitation to attend the intervention, she was randomised and immediately informed of her allocation on the telephone. If she was allocated to the control group she was reminded that she was still important to the study and we would like to see her when her baby was 3 months old. If she was allocated to the intervention group, the RA went through the practical details of the classes. An appointment time was also agreed for the initial meeting with the course leaders prior to the start of the intervention classes.

If the participant was uncontactable by telephone a letter was sent asking her if she would like to have the opportunity to attend the 'Preparing for Parenthood' classes. A freepost envelope was enclosed for her reply. All women were contacted at this stage, the majority by telephone.

2.7 Intervention

The development of the intervention is described in detail below as this was the health-promoting behaviour being measured. Procedural issues are also covered .

2.7.1 The Development of the Antenatal Intervention 'Preparing for Parenthood'

In addition to a wide literature review of previous psychosocial interventions involving parents and /or mental health issues, a market research survey was undertaken to inform the practical implementation of the intervention. The recruitment of mental health clinicians and the training they required to be course leaders for the intervention will be outlined. Three pilot intervention groups were run in total - modifications to the resulting content and implementation will be detailed. The final intervention course structure and content, the monitoring and supervision of the course leaders, and their adherence to the intervention package are also described.

2.7.1.1 Background

The aim was to design and develop an antenatal intervention, 'Preparing for Parenthood', that reduces the four psychosocial risk factors of postnatal depression previously identified in this population from an earlier cohort study (N = 507, Brugha et al. 1998) . These were:

- the level of depression in pregnancy,
- an unplanned pregnancy,
- an unsupportive response to the pregnancy from the woman's partner and/or
- an unsupportive response to the pregnancy from the woman's mother.

The chosen area for this intervention study was social support with key others, as this relates to the major life change occurring as a result of a first pregnancy. The intervention is seen as aiming to achieve change both in the woman's personal social environment and also in herself, particularly in the way she copes with practical and emotional demands. Hence the intervention emphasises two key ingredients: training in appropriate social problem-solving and coping skills (Nezu *et al.*, 1989); and recruitment of social support from the existing network and from a peer group of other women in the same life stage.

2.7.1.2 Elements of the 'Preparing for Parenthood' Intervention package

The intervention draws on Parry's (1995) model of social support which emphasises cognitive and interpersonal processes. This model makes sense of many of the diverse research findings about the specifics of social support networks and mental health. It concluded that the focus on perceived support is more relevant than measures of objective support.

This intervention needed to address aspects of current cognitions. In particular, it addressed attitudes to pregnancy and motherhood, participant's predictions of their future situation, and since prior depressive symptoms have been identified as a clear risk factor, these were also attended to. The format of the manual was based on the Kirkham *et al.* (1988) manual because their intervention was reported clearly, and appeared to be easily replicable. We added elements to increase clarity and to enhance the course leaders' involvement. Design and content of the weekly sessions drew on the work of Kirkham *et al.* (1988) and Elliott *et al.* (1988).

Personal problem-solving, social support, information about PND, open sharing and cognitive aspects were the 5 central components of the intervention. The package also drew on the qualitative work of Wolkind & Zajicek (1981), Oakley (1979), and Breen (1975). These latter works provided invaluable background information for the course leaders about the likely concerns and experiences of women in the groups, and could be offered as information to participants to help them feel part of the cohesive group.

2.7.1.2.1 Three elements drawn from previous studies and incorporated in this intervention.

1. *Including the partner/significant other in the intervention:* Holden *et al.* (1989) cite a frequent criticism by fathers of antenatal preparation. They reported feeling left out, that their role in the antenatal preparation was unclear, and that they (and their partner's) wished that they had been warned of the possibility of mood swings both before and after the birth of their child. Elliott *et al.* (1988) successfully included partners in the PND session of their study. Kirkham (1993)

raised the question of whether partners should have been included so that as women developed new ways of coping this could be shared, thus avoiding it becoming a source of conflict. Partners were therefore invited to the PND session in the present study and were introduced to the problem-solving SODAS model.

2. The style of the groups should be empowering and focus on developing current strengths:

Jenkins (1992) comments that good practice in prevention should include helping people find their own solutions and draw on and strengthen existing support systems. Oakley (1979) suggested the need to offer “expertise of a personal and practical kind”; this was heeded and it was attempted to reduce the gap between health professional and mother by warming the climate of the group meetings and relaxing the style of the leaders input.

3. Anticipatory guidance is better than psychodynamic counselling: In line with the recommendations of Shereshefsky & Yarrow (1974) the intervention focused on the future and was structured accordingly.

2.7.2 Market Research Survey : Practical considerations in designing an intervention that women would be interested in attending.

The practical implementation of the intervention was investigated in the form of a market research survey. The issues addressed included whether or not the women would be interested in attending the proposed classes, and more specific questions about the content, format, location, and timing of the classes.

The survey consisted of a semi-structured interview, including a number of open ended questions and others requiring rated responses. A small sample of 14 women, 6 of whom were primagravidas, were approached at their first antenatal clinic appointment at the Leicester General Hospital. 12 questionnaires were fully completed and returned. The primagravidas were asked whether they would be interested in attending the proposed classes during the second part of their pregnancy. The multigravidas were asked to think themselves back to the time when they were pregnant with their first child and respond from that perspective. It was made very clear that these classes would be in addition to the usual midwife-run Parentcraft classes, and that they were still in the planning stage and would not be available for these women at this time.

This small survey seemed to suggest that the sort of intervention proposed would be of interest to the majority of pregnant women. The suggested content seemed broadly relevant to most women. The format most preferred was either a series of about 6 weekly meetings, or about 3 or 4 half day workshops. Evenings were not popular: weekday mornings or afternoons were

preferred. It would appear that even though these women mainly attended or were planning to attend local Parentcraft classes, they said they would be prepared to travel to Leicester General Hospital for the proposed classes. Involvement of significant others at some stage in the classes was welcomed. Provision of an explanatory leaflet prior to the classes beginning was viewed positively. The obstacles anticipated were largely related to the atmosphere or content of the group; venue did not emerge as an issue. It was clear that course leaders would need to be sensitive to what the participants wanted to discuss and pick up anxieties about feeling, for example, stupid and/or overanxious.

2.7.3 The Course Leaders :

As the course leaders were the vehicle for providing the intervention, their selection, training and supervision will be described .

2.7.3.1 Selection

The intention was to create a “pool” of course leaders meeting the following criteria: (1) Course leaders should include both parents and non-parents, so that there would be one parent and one non-parent running each course; (2) Course leaders should include men and women; (3) Course leaders could come from a range of professional backgrounds. No single profession was considered most appropriate; course leaders were recruited from psychiatric nursing and occupational therapy, but theoretically might have included psychiatric social workers, clinical psychologists or psychiatrists.

Of the seventeen trained, 14 people participated as course leaders during the study. The attrition of three course leaders was due to a combination of factors including their own pregnancies and resulting maternity leave rendering them unavailable to run a group. Of the fourteen, 11 were women (5 were parents at the outset of the study), and 3 were men (all parents). All were qualified mental health clinicians, with a training in either psychiatric nursing (n=10) or occupational therapy (n=4). Each had a minimum of 2 years post qualification experience. All selected course leaders met the following requirements:

1. They had had experience of running structured, time-limited groups, and were broadly familiar with cognitive behavioural approaches or problem solving models, although none had had any previous specialist training in these areas;

2. They had had experience of working with depressed women, a few had specific experience of working with women with PND;

3. They were known in a professional capacity to at least one clinician on the steering committee, and were considered to be able practitioners who were likely to be able to deliver the intervention package effectively, and to adhere to the rigorous demands of the research.

2.7.3.2 Training

Training consisted of the following components:

Formal training in the use of the intervention package: 3 days group training, conducted by the author of the intervention, assisted by a Research Associate. This consisted of introducing the study, providing the rationale and background information, going through the package in detail, and role playing some of the exercises.

Reading: Course leaders were provided with several key articles which would orient them to the client group and provide background information. Additional material was readily available in the research team's office if they wanted further information of either a theoretical or practical nature in the form of a 'library' of references selected to orient them to the task at hand.

Update meetings: These meetings with the author, researchers, supervisors and course leaders occurred approximately every 3 to 4 months, and provided a forum for clarification of changes to the intervention or research process (especially during the pilot phase).

2.7.3.3 Supervision

There were three supervisors: one female clinical psychologist, one female OT, and one male OT. They shared responsibility for the supervision sessions with the course leaders. The content included:

- Reflection on the previous week's meeting, discussion of problems encountered either in delivering the intervention or in managing the group process;
- Preparation for the forthcoming meeting, reminding themselves of the content and rationale of the meeting, and addressing anticipated problems;
- An opportunity to share the conflicts, frustrations and anxieties that arise at the research/clinical interface, and discuss administrative problems that affected their motivation;
- Input from the supervisor about adhering in detail to the content and process of the research. This included advice on keeping records of any variations or omissions from the intervention package, holding the position of a "course leader" rather than their usual role as "therapist", and challenging "slippage".

The course leaders of the next group also took part to refresh their memories of the structure and practicalities of the intervention. This procedure provided a 'buffer zone' between the course leaders and the research team. Significant difficulties could be communicated to the RA, to be dealt with by the research team. The more day-to-day challenges arising from the groups were dealt with by the course leaders with guidance from the supervisors.

As course leaders became more experienced in providing the intervention, the nature and length of supervision changed. It continued to be weekly, but often only lasted about 30 minutes, and tended to focus mainly on the last two points above. Course leaders became confident in applying the package and managing the groups, but needed continued help in keeping tightly to the details.

2.7.4 Pilot Study :

Piloting was initiated in the winter of 1995 after the training of the course leaders was completed in autumn 1995. Three separate pilots of all procedures were carried out, each differing from and building upon the previous one. Changes made between the pilots and the actual trial intervention will be described in this section. The third and final pilot of the intervention was completed at the end of March 1996 and the first set of intervention classes of the trial began in May 1996.

2.7.4.1 Suggestions for Modification

The intervention was altered in a number of ways from the three sets of pilot study data. Some minor amendments were made to the content of the intervention as a result of piloting, and a number of procedural issues and omissions were identified and addressed. However the general format and content areas were maintained and initial feedback from the 3 pilot groups showed that women who took part found the intervention helpful and enjoyable.

Helpful aspects mentioned several times in the open feedback questions included all of the central components. Those mentioned the most were: addressing social support issues, sharing their feelings, information about PND, the SODAS problem-solving model, thoughts and how to change them.

The alterations made were based mainly on the participants feedback, the course leaders feedback, and the level of engagement of the group. There were three major alterations as follows.

1. The timing of the intervention was altered so that the intervention began at approximately 28/30 weeks gestation. Groups starting earlier encountered difficulties with work and low

engagement due to not really “feeling pregnant”; groups starting later encountered difficulties getting to the classes due to not “fitting behind the steering wheel” or feeling too vulnerable to travel on their own on public transport and low engagement due to ill health - “I should be putting my feet up”.

2. The initial meetings were held at 30 minute intervals on one day in the room in which the ‘Preparing for Parenthood’ intervention classes were held. Initial meetings at the women’s homes took the course leaders longer due to them having to travel between participants houses over several evenings in their own time. In addition, there was no guarantee that the woman would be at home despite the time of the visit having been arranged for the participants convenience. Ultimately the home visits were not only more costly in terms of finance to the project, but also the loss of goodwill from the course leaders.

3. The order of the sessions for the intervention were altered to try and engage the women as quickly as possible and increase a feeling of group cohesiveness. The sharing exercises were moved back until the women felt a little more sure of themselves, of the course leaders and of their fellow participants. The contents of the first two sessions were trimmed due to a feeling of “being rushed” that was reported by the course leaders.

2.7.4.2 An Opportunity Lost?

The confines of the RCT trial design limited the type and number of modifications that could have been made to the present study of engagement with an antenatal psychosocial intervention. The inclusion of a measure such as a short postal questionnaire to explore the women’s reasons for not engaging, tailored to be relevant to the point at which they declined to take any further part in the study, would have been relatively simple to construct and inexpensive to carry out. However, the inclusion of such an additional measure after the commencement of the RCT trial may have compromised the design and results of the quantitative study. The ideal time (with hindsight) to implement the use of just such a measure was at the end of the pilot study. This was when myself and the research team had just begun to understand the impact engagement, or rather the lack of it, would have on the RCT trial. The inclusion of a measure of engagement, or perhaps more appropriately, a measure exploring the reasons for non-engagement would have provided a data set richer in information than is actually available. Nevertheless, as mentioned in the rationale (section 1.4.2), it was at this point in time that the bud of this thesis was beginning to form in my mind.

2.7.5 The Intervention :

The intervention was fully documented in a training and operational manual that included checklists and feedback forms for completion by course participants and course leaders. See supplementary appendix for the actual intervention package.

2.7.5.1 Structure

The intervention consisted of six two hour sessions held every week preceded by an initial introductory meeting and followed by a postnatal reunion session. The women were invited to attend on their own for the sessions, hopefully to reduce inhibition since the majority of sessions involved single sex groups. Every effort was made to ensure that the women were at a similar stage in their pregnancies - no more than 8 weeks difference between the individuals who were the least pregnant and the individuals who were the most pregnant. The women were an average of 26-28 weeks gestation when they began the classes. Each group comprised of at least 10, but no more than 15, women.

The initial meetings were held at half hourly intervals over one full day as much as possible. They were spread over two afternoons or mornings if the rooms were unavailable or the course leaders had other commitments to take into consideration. The course leaders would meet for between half an hour and an hour prior to the first appointment time. This allowed them to refresh their minds once more to their task and ensure that they had all the necessary handouts, questionnaires, and checklists. The course leaders carried out at least the first two initial meetings as a pair, they then worked individually carrying out parallel initial introductory meetings.

If a participant did not keep her initial meeting appointment, and no message was received from her, one of the course leaders telephoned her the next day to see if she was well, check whether she had difficulties getting to the LGH for the group, and reassure her that she would be welcome the next week for the first session. Any questions she may have had were answered by the course leader, and she was told that they looked forward to seeing her at the group the following week - should she have any problems before then she was told she could always call the research teams telephone number and speak to one of the Researchers.

All of the classes were antenatal and were scheduled not to clash with the midwife-run Parentcraft classes, which tend to focus on obstetric and infant care and start at around week 32. The two hour sessions included a tea/coffee break of about 15 minutes midway through the session. The third session (of the six) was a meeting open to the partner or significant other and

the 2 course leaders were joined by an additional male nurse who worked with the participants' male partners during the session.

A final 'reunion' class took place approximately two to three months after childbirth, at which the women were encouraged to renew their friendships and explore ways of continuing to obtain the support they need before any problems become insurmountable.

An attendance sheet listing the participants of the classes was completed for each session by the RA. Various standardised procedures were followed regarding participants' missing a session, dependent upon whether they had missed one, or more. The first session that a participant missed without an explanatory message (for example, by telephone) was followed up: she was sent the handouts from that session along with a covering letter from her course leaders, expressing the hope that she was well and reminding her to telephone the team if she had any queries. Should a participant have failed to attend two consecutive sessions without explanation, she was no longer sent the handouts from sessions she had missed. If a participant did not attend any of the sessions, including the initial meeting, she was sent an abbreviated (standardised) 'Preparing for Parenthood' selection of handouts. The information included the postnatal depression symptoms and social support issues drawn from the relevant intervention sessions.

2.7.5.2 Content

The following themes were the focus of at least one group: being aware of and acknowledging problems, facts about emotional problems and postnatal depression, available support and effective support seeking, and problem solving with the help of others. These combined various aspects of the 5 central components.

Based on the earlier cohort, a strong focus was placed on the woman's future material circumstances after child-birth including her housing, income sources, and dependency on others. Cognitive behavioural techniques were used, where appropriate, in order to restructure the women's perceptions of potentially available support from Key others, based on the model of cognitively-based support therapy developed by (Parry, 1995). Educational material from a variety of sources were also incorporated.

As the intervention was primarily structured to reduce PND through enhancing psychosocial support, various aspects of the intervention addressed this issue. These included exploring attitudes toward seeking support, the exploration of current and potential support networks, and identification of areas that participants said they would like to develop in relation to the demands

of being a mother. Attention was paid to developing assertiveness and communication skills that are essential elements in developing and maintaining effective social support networks. Conflicts and disappointments with partners and other support figures formed much of the discussion during the sharing exercises of the sessions. Dealing with the absence of expected support was specifically addressed. Within the group, participants were encouraged to learn how to offer support to each other and to ask for the practical or emotional support they felt they needed. They were invited to form a “buddy system”, and to regard the group as a continuing source of support, together with the midwifery and health visiting services.

2.7.5.3 Monitoring

To ensure that the presentation of the intervention and any effects it may have had could be confidently assumed to be consistent over the period of the study, one of the researchers took overall responsibility for assuring the quality standards of the intervention package. Monitoring procedures and standards were developed as part of the overall package. It was accepted that it was not feasible, within current research constraints, to monitor the course leaders adherence to the package directly through audio or video recordings. Accordingly, indirect measures were devised, and the intervention was designed, written and supervised in such a way as to promote adherence amongst the pool of course leaders and maintain the integrity of the intervention.

At the end of each session the women and the course leaders each completed a standardised feedback form to rate the extent to which they felt that each of the core topics had been covered during that session. The participants were also asked to rate how helpful they had found the meeting and indicate the most and/or least helpful part of the session. The course leaders, in addition to completing the feedback form, also completed a checklist to ensure that they had covered everything they were required to cover and how much emphasis had been apportioned to the topics under discussion as indicated by the time spent on each part of the session. This was done to try and ensure that any engagement issues that arose could be attributed to the intervention as it is presented in the appendix, and not to an unknown, unstandardised part of the intervention which could not be confidently accounted for.

2.8 Outcome Assessment:

At the 3 month outcome assessment (OA) the sample was interviewed repeating all those measures assessed at baseline. This involved not only the intervention (compliant and non-

compliant) and control women but also those women who decided they would not like to attend the intervention (the refusers), providing they had consented.

2.8.1 Arranging the Outcome Assessment

All women were contacted by telephone at about 3 months postnatally, again in expected delivery date month batches. The RA (JS) was blind to the allocation of the participants but did know which were members of the refusers sub-set since no clinical interview schedule (SCAN) was completed for them. The outcome assessment was arranged following the same procedures as for the baseline assessment.

2.8.2 Enhancing engagement at Outcome Assessment

The majority of women were at home for their appointments. If a woman was not at home the standard procedure was followed as for baseline. A system was followed such that 2 rearranged appointments for which the woman was not at home, a letter was sent expressing regret that the time has now passed “when we could have met for a chat” and thanking her for her involvement in the research.

2.8.3 Consent at Outcome Assessment

The standard participant information for the outcome assessment was as follows:

“We are now evaluating our additional service for expectant mothers. In order to evaluate this new service, the Preparing for Parenthood course, you may remember that we have to compare it with the existing antenatal maternity care service. Because we only have a limited amount of resources we could only offer this new service to a select few. You may or may not have been randomly selected for the Preparing for Parenthood course. Please do not tell me if you did or did not attend the Preparing for Parenthood course as this may effect our research adversely. We do hope that you will agree to continue to help with our work. If, however, you decide you do not wish to continue with our work you may say so at any time as your participation is completely voluntary.”

This was read out to the participant. Upon the participant's agreement to consent the outcome assessment was then carried out in a pre-established order of component questionnaires and interviews.

2.8.4 Measures used at Outcome Assessment

The same self completion and investigator-rated outcome assessments were conducted at the outcome assessment as for the baseline assessment. The measures of health-promoting behaviour were: for LOC the Fetal Health Locus of Control scale (FHLC; Labs & Wurtele, 1986), Meltzer *et al.*, 1995) for psychosocial support Interview Measure of Social Relationships (IMSR; Brugha *et al.*, 1987) and the Antenatal Social Support questionnaire (derived from the screening questionnaire; Brugha *et al.*, 1998); and for negative life events the Obstetric & General Life Events questionnaire (adapted from Barnett *et al.*, 1983).

In addition to these and the other measures repeated from the baseline assessment, a clinical interview, the 10th version of the Present State Examination (SCAN; Wing *et al.*, 1990), was administered to the randomised participants by a trained interviewer with no knowledge of the care (or treatment assignment) of the woman. Those women who had been allocated to the intervention group were sent a course feedback form at between 3 and 4 months postnatal to return to the team to assess what they found useful about the intervention. This was carried out by the RA not completing the outcome assessments and thus did not need to be and was not blind to the participants allocation.

2.8.6 Monitoring Blindness

As far as possible, the research team attempted to achieve 'double blind' conditions. That the RA was blind to the women's allocation to either intervention or control groups was ensured via a monitoring procedure. This was done to attempt to control for investigator effects and thus remove them from the list of possible confounding factors of the study. This involved recording which group she thought the randomised (intervention or control) participant had been allocated to. This judgement was based on the RA's perception of the participant's problem solving abilities and coping skills as illustrated during the outcome assessment. If their skills were perceived to be good this might have indicated that the participant had attended the intervention. This procedure was carried out retrospectively at the end of each day.

2.8.5 Preparing the participant for future follow-ups

When the information-gathering section of the outcome assessment was completed, if the woman had been randomised, the RA went on to outline the next stage of the study i.e. the outcome assessment to be carried out at 12 months, which will not be reported here.

2.9 Plan of analysis

The plan was drawn up approximately 3 months prior to the commencement of the analysis stage of the study, (see appendix 1 for the analysis plan). The plan was followed up to point 8 in the secondary analysis when it became apparent that it was no longer appropriate to investigate further. The three sub-groups of compliant, non-compliant and refuser were to be compared and contrasted to attempt to identify antenatal predictive factors that could be used in screening women for engagement in an intervention.

Logistic regression was used to analyse the data as the outcome variables that were investigated in the present study were presented as binary outcomes. This was instead of presenting the variables as continuous outcomes, which would have necessitated the use of linear regression analyses; or presenting the variables as categorical outcomes, which would have necessitated the use of ordinal logistic regression (Everitt, 1989). It was decided to produce binary outcome data using binary cut-points for each variable as this enables the more straightforward presentation of findings in terms of the presence or absence of an entity, such as, for example, depression or high internal LOC.

The cut-point for engagement was based on the considered thoughts and opinions of the group of researchers involved in the design and implementation of the intervention. It was decided that the minimum number of sessions of the intervention that an individual would have had to have been exposed to to achieve an effect were the one discussing postnatal depression and at least two of any of the other sessions. Thus the sample was broken down to reflect actual attendance of, and engagement in, the intervention. The intervention group was divided into two: those who attended session 3 (concerned with postnatal depression) plus at least two other sessions: 'compliant'; and the remainder of the intervention group: 'non-compliant'. Therefore, instead of three sub-groups the study sample now consisted of four: refusers, compliant, non-compliant and control participants. This was intended to allow analysis of the intervention in terms of participants who had *actually* received (or not received) the core parts of the package i.e. postnatal depression symptoms and social support issues, and not just analyses reflecting assignment to receive (or not receive) these core topics. The engagement sub-groups that are of interest to this thesis are the compliant, non-compliant and refuser participants (who declined to be randomised at baseline).

These sub-groups were analysed in terms of three measures of health-promoting behaviour. The cut-points for these measures were decided arbitrarily based on the assumption that the data would be normally distributed. This was set at three-quarters of the total possible score for the

sub-scales of the measure of locus of control FHLC and the measure of psychosocial support, the simple presence or absence of the experience of any of the sub-scale measures of life events was decided on as the cut-point for negative life events as it was felt it was unlikely that the women would have experienced more than one of the events listed and was recommended by Brown & Harris (1978).

3 Quantitative Study Results

3.1 Attrition of the sample

Figure 3.1 shows the number of women participating at each stage. The percentages shown in brackets are totalled in columns, each of which represents a stage of the trial. Of the 1300 participants who completed the screening questionnaire, 400 scored as having low mood on the GHQ-D (≥ 1).

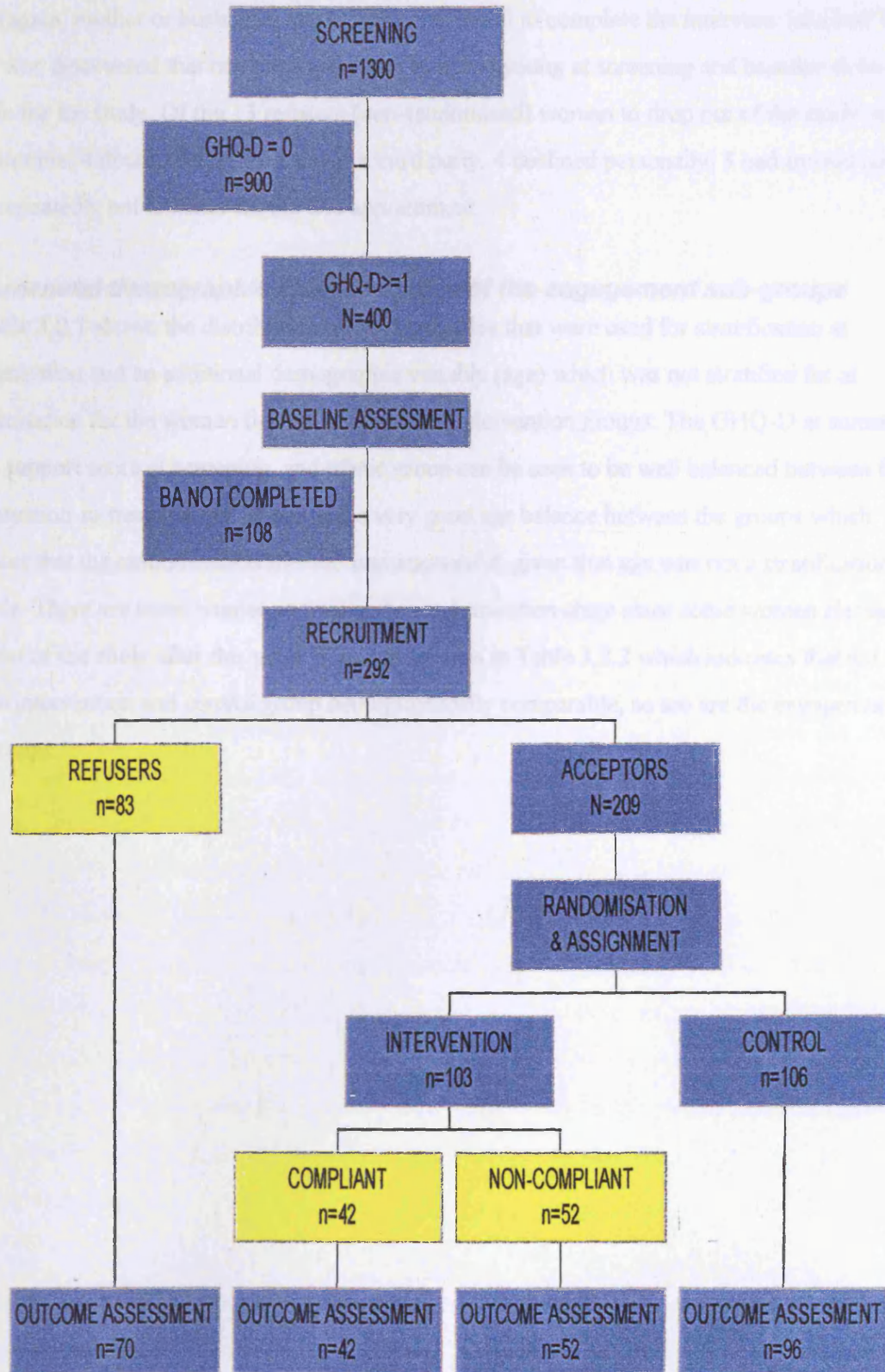
The greatest loss of participants occurred between the screening and baseline assessment (BA) stages. A total of 108 (27%) were either not seen, or it became apparent that they were ineligible for the trial. There were three main categories for non-completion of the BA; they declined the BA (39/108, 36%), were not at home for the BA (33/108, 30%), or the participant was 30 weeks + gestation when she returned her screening questionnaire and therefore would not be able to complete the intervention should she be allocated to that randomisation group post-BA (15/108, 14%). Ineligibility became apparent either at the point of telephone contact due to lack of spoken English (10/108, 9%) or at the beginning of the baseline assessment interview (11/108, 11%).

At the stage where the women were invited to have the opportunity to attend the intervention (recruitment), 83 women refused to be randomised and 209 went on to be randomised and allocated to either the intervention or control groups. Unfortunately, as mentioned previously, more detailed data regarding the reasons for non-engagement in the intervention are not available at this point of the study as no measures of this type were completed by the refuser women at this stage of the study.

Post-randomisation the control group had no further contact with the study until the outcome assessment. Nonetheless, the intervention group, by its very nature, was intended to have further contact with the study. However, of the individuals completing an outcome assessment, only 42 participants of the intervention group met the criteria for the engagement cut-point to be considered members of the compliant sub-group, the remaining 52 were members of the non-compliant sub-group. Exploration of the reasons for this dichotomy are central to the analyses

At the outcome assessment (OA) 9 of the randomised intervention women and 10 of the randomised control women dropped out of the study. Of the intervention women, 2 of the women who dropped out were compliant and 6 were non-compliant. The reasons given for the compliant women were: that one had a seriously ill baby and that the other had moved without a forwarding address. The reasons given by the non-compliant women were: four declined the follow-up

FIGURE 3.1 QUANTITATIVE STUDY ATTRITION



interview through a third party (mother or husband usually), and two had moved without leaving a forwarding address.. The control women gave the following reasons for declining an OA: five had moved house without leaving a forwarding address, four declined the follow-up through a third party (again, mother or husband), one woman was too ill to complete the interview (she had TB), and it was discovered that one participant had been too young at screening and baseline to be eligible for the study. Of the 13 refusers (non-randomised) women to drop out of the study at this point in time; 4 declined the OA through a third party, 4 declined personally, 3 had moved and 2 were repeatedly not at home for the OA appointment.

3.2 Antenatal demographic characteristics of the engagement sub-groups

Table 3.2.1 shows the distribution of the 3 variables that were used for stratification at randomisation and an additional demographic variable (age) which was not stratified for at randomisation for the women from the control and intervention groups. The GHQ-D at screening, social support score at screening, and ethnic group can be seen to be well balanced between the two intention-to-treat groups. There was a very good age balance between the groups which indicates that the randomisation method was successful, given that age was not a stratification variable. There are more women in total at the randomisation stage since some women elected to drop out of the study after this point. This can be seen in Table 3.2.2 which indicates that not only are the intervention and control group demographically comparable, so too are the engagement sub-groups.

VARIABLE	STRATIFICATION LEVEL (WHERE APPROPRIATE)	INTERVENTION	CONTROL
GHQ-D	HI>=3	23 (22%)	24 (23%)
	LO<=2	80 (78%)	82 (77%)
SOCIAL SUPPORT	HI>=6	16 (16%)	18 (17%)
	LO<=5	87 (84%)	88 (83%)
ETHNIC GROUP	EUROPEAN	75	77
	ASIAN	28	29
AGE: MIN		16	17
Q1		9.5	9.5
MEDIAN		19	19
Q3		28.5	28.5
MAX		38	38
TOTAL		103	106

Table 3.2.1 - Distribution of stratification and non-stratification variables for the intervention and control groups.

Although a balance was achieved via stratification for age and ethnicity in the sub-groups, self-selection may have led to different distributions of this data. Table 3.2.2 below shows that there was very little difference at baseline between these three sub-groups of participants for these variables. Even those members of the population not randomised, i.e. the refusers, appear to be very similar to the trial sub-sample, although there are slightly more Asian women in the refuser sub-sample. However, a trend with regards to the mean age of participants at baseline became apparent. Younger women either declined the invitation to the intervention (refusers) or intended to participate but did not actually attend the intervention (non-compliant); whereas, older women both intended to attend and did actually attend (compliant). However, these differences were so small as to not warrant a statistical analyses, particularly when taken into consideration with the distribution data given for each of the sub-groups. Nonetheless they are included as a potentially worthy point of interest.

	COMPLIANT	NON-COMPLIANT	REFUSERS
AGE:			
MEAN	27.5	24.2	25.0
MIN	18	18	16
Q1	9	9.25	9.25
MEDIAN	18	18.5	18.5
Q3	27	27.75	27.75
MAX	36	37	37
ETHNIC GROUP:			
WHITE	30 (71.4%)	37 (71.2%)	58 (66%)
ASIAN	12 (28.6%)	13 (25.0%)	27 (30%)
OTHER	0	2 (3.8%)	3 (4%)
TOTAL	42	52	88

Table 3.2.2 Demography of three engagement sub-groups at baseline

3.3 Antenatal health-promoting behaviour characteristics of the engagement sub-groups

The next stage of the analysis compared the engagement sub-groups with respect to the frequency scores of the three health-promoting variables of locus of control, psychosocial support and negative life events. This section simply *describes* the differences between the distributions of the measures for the sub-groups, the hypothesis testing begins in section 3.5 where statistically predictive health-promoting variables are explored.

For each of the FHLC sub-scale scores the same binary cut-point was applied: low internal, chance, or powerful others LOC (scores ≤ 41); or high internal, chance, or powerful others LOC (scores ≥ 42). For each of the social support scores a binary cut-point of poor perceived support (scores ≤ 10) and good perceived support (scores ≥ 11). For the negative life event sub-scale scores the binary cut-point that was used was simply the presence (scores ≥ 1) or absence (scores = 0) of a recent life event.

3.3.1 FHLC

The frequency of each of the fetal health locus of control (FHLC) sub-scale scores for the compliant, non-compliant and refuser subjects at baseline are shown below. The data for all three sub-scales are not normally distributed, the internal and chance sub-scale item frequencies are negatively skewed, the powerful others sub-scale scores have a positive skew. No transformations appreciably rectified this data.

3.3.1.1 Internal sub-scale

Figure 3.3.1.1.1 Frequency of internal sub-scale scores for the compliant sub-group

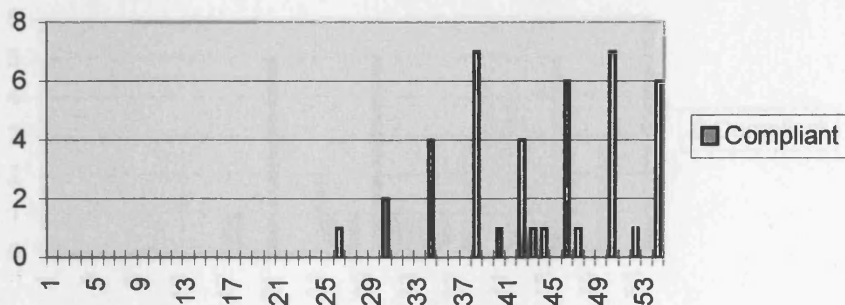


Figure 3.3.1.1.2 Frequency of internal sub-scale scores for the non-compliant sub-group

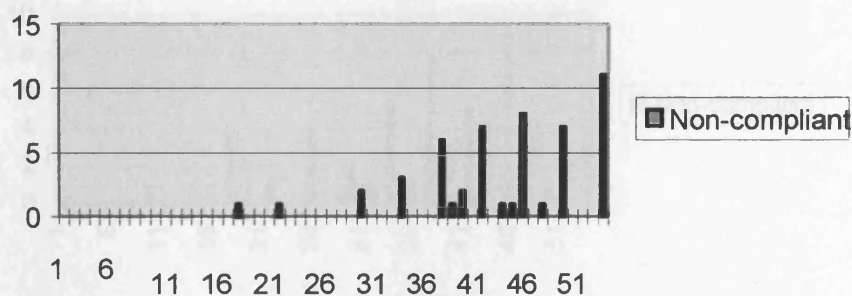
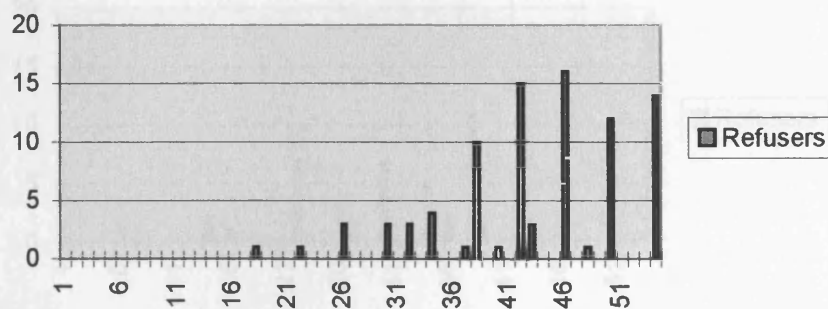


Figure 3.3.1.1.3 Frequency of internal sub-scale scores for the refuser sub-group



3.3.1.2 Chance sub-scale

Figure 3.3.1.2.1 Frequency of chance sub-scale scores for the compliant sub-group

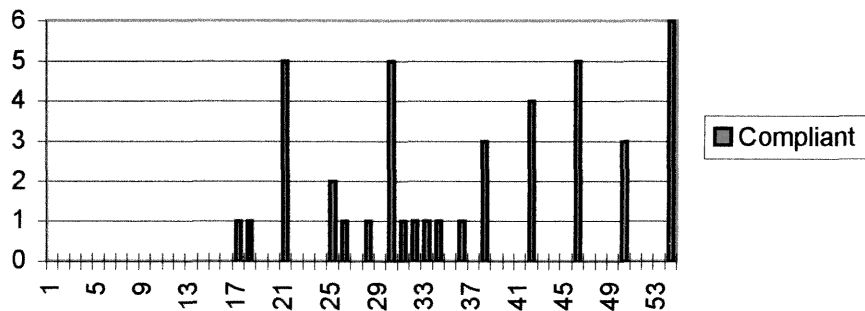


Figure 3.3.1.2.2 Frequency of chance sub-scale scores for the non-compliant sub-group

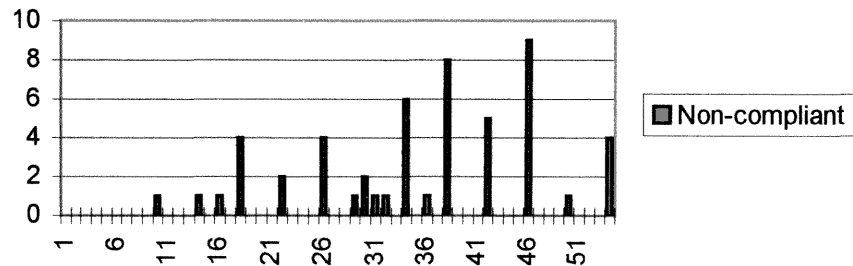
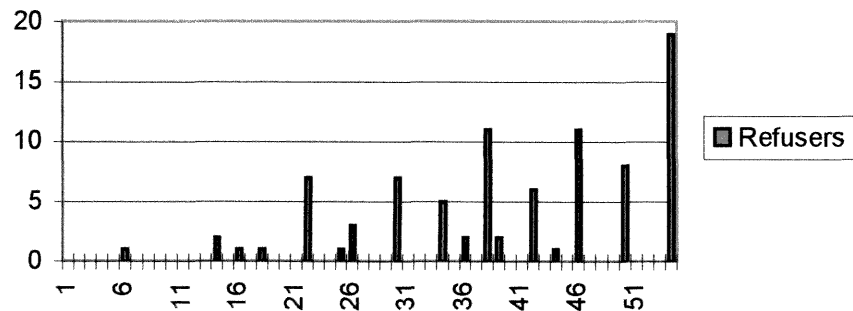


Figure 3.3.1.2.3 Frequency of chance sub-scale scores for the refuser sub-group



3.3.1.3 Powerful others sub-scale

Figure 3.3.1.3.1 Frequency of powerful others sub-scale scores for the compliant sub-group

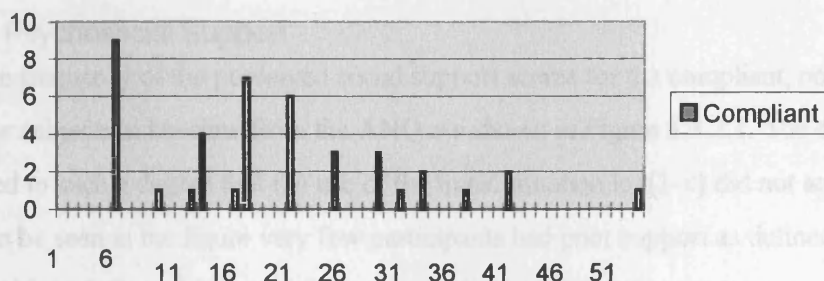


Figure 3.3.1.3.2 Frequency of the powerful others sub-scale scores for the non-compliant sub-group

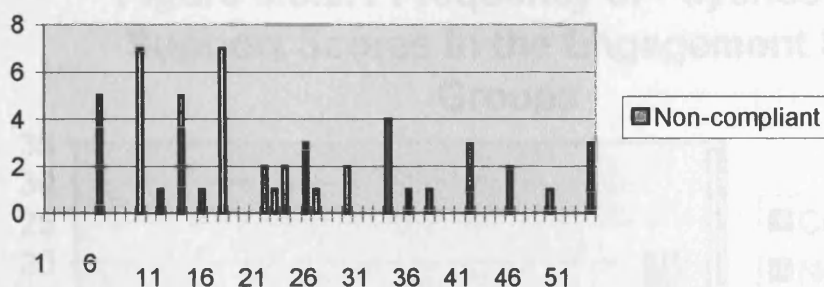
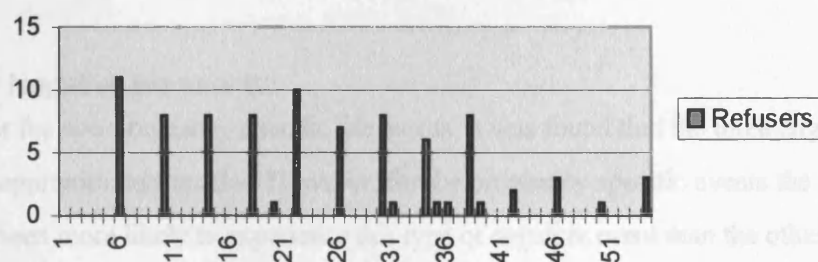


Figure 3.3.1.3.3 Frequency of the powerful others sub-scale scores for the refuser sub-group

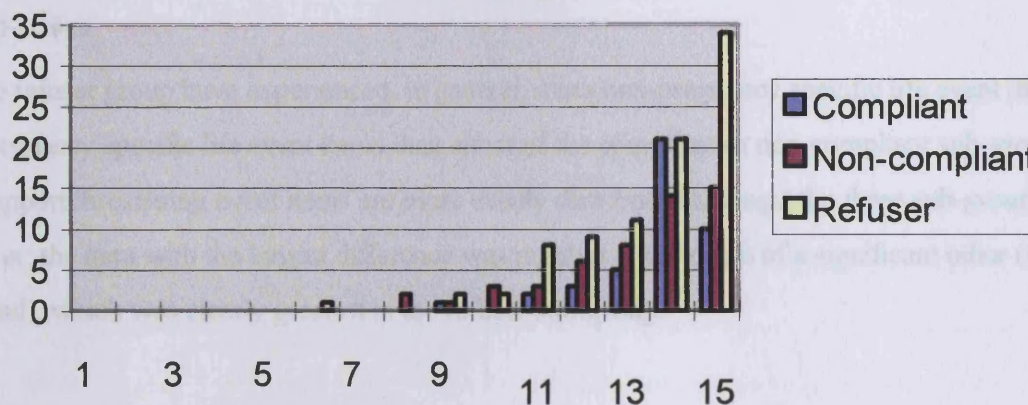


In summary, the compliant sub-group had the lowest number of individuals with high internal LOC. The non-compliant sub-group had the lowest number of individuals with high chance LOC and the greatest number of individuals with high powerful others LOC. Finally the refuser sub-group had the greatest number of individuals with high chance LOC.

3.3.2 Psychosocial Support

The frequency of the perceived social support scores for the compliant, non-compliant and refuser subjects at baseline from the ANQ are shown in Figure 3.3.2.1. The data were negatively skewed to such a degree that the use of the transformation $\log(1-x)$ did not appreciably rectify it. As can be seen in the figure very few participants had poor support as defined by the cut-point of ≤ 10 although the refusers and the non-compliant participants appear to perceive that they are less well supported than the compliant individuals perceive themselves to be.

Figure 3.3.2.1 Frequency of Psychosocial Support Scores in the Engagement Sub-Groups



3.3.3 Negative life events

For the non-pregnancy specific life events, it was found that the three engagement sub-groups were approximately similar. However, for the pregnancy specific events the refusers seemed to have been more likely to experience this type of negative event than the other sub-groups. Conversely, the refusers were less likely to experience support threatening events than the compliant and non-compliant sub-groups. These two groups were the most comparable engagement sub-groups of the three for this health-promoting variable with very little variance in the type of negative life events experienced in their recent past.

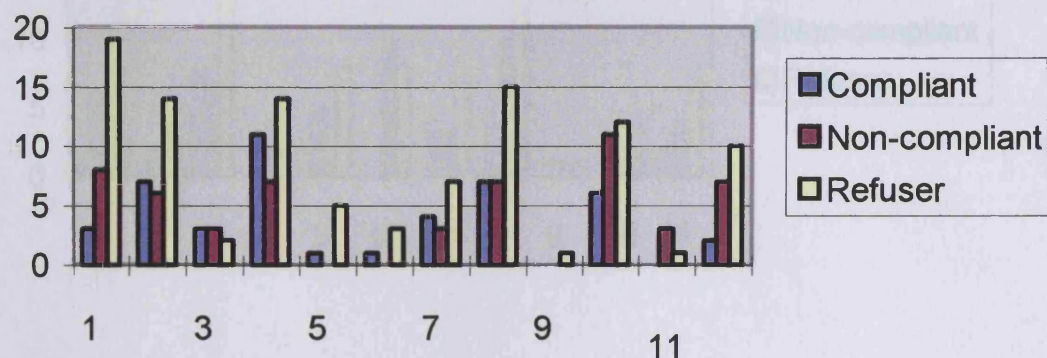
	Compliant (n=42)	Non-compliant (n=52)	Refuser (n=88)
Non-pregnancy specific	27 (64%)	34 (65%)	53 (60%)
Pregnancy specific	20 (47%)	25 (48%)	52 (59%)
Support threatening	18 (42%)	25 (48%)	32 (36%)

Table 3.3.3 Frequency and percentage of negative life event sub-scale scores for the engagement sub-groups

As the cut-point for this variable is simply the presence or absence of a negative life event in the 12 months prior to baseline, it was decided to explore further the distribution of each type of life event for the sub-scales amongst the engagement sub-groups. The frequency of the negative life event sub-scale items for the compliant, non-compliant and refuser subjects at baseline are shown in Figures 3.3.3.1, 3.3.3.2, and 3.3.3.3. The tables accompanying list the items for each of the sub-scales.

The refuser group have experienced, in general, more non-pregnancy specific life event items and pregnancy specific life event items than either of the compliant or non-compliant sub-groups. The support threatening event items are more evenly distributed amongst the three sub-groups, however, the item with the largest difference was number 4, the death of a significant other (family or friend), which was clearly greatest in the refuser sub-group.

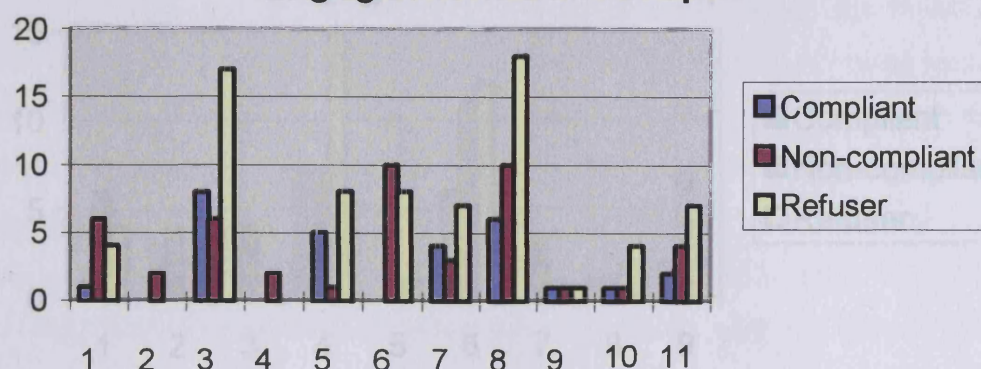
Figure 3.3.3.1 Frequency of Non-pregnancy specific life event items for the engagement sub-groups



ITEM NUMBER	ITEM DESCRIPTION
1	Separated from family/close friend
2	Major financial crisis
3	Serious illness / badly injured
4	Significant other developed serious illness
5	Partner became unemployed
6	New person living in household
7	Serious illness during pregnancy
8	Significant other died
9	Partner died
10	Serious arguments with partner
11	Legal problems
12	Separated from partner

Table 3.3.3.1 Non-pregnancy specific life event items

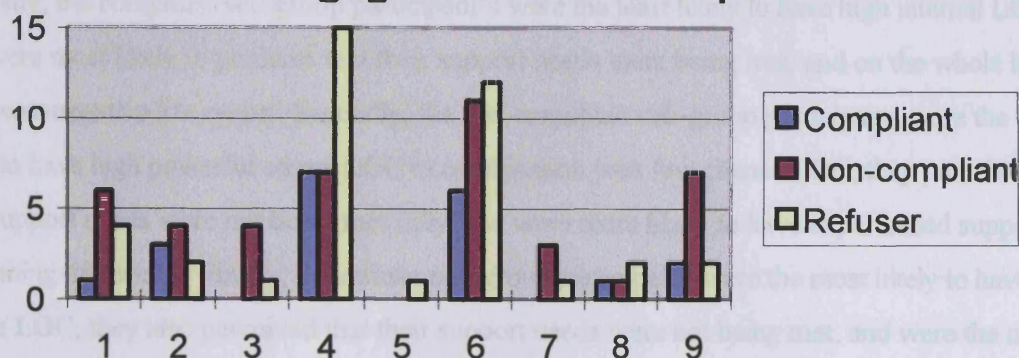
Figure 3.3.3.2 Frequency of Pregnancy Specific Life Event items in the Engagement Sub-Groups



ITEM NUMBER	ITEM DESCRIPTION
1	Partner not want pregnancy
2	Had an X-ray
3	Sexual problems during pregnancy
4	T.O.P
5	Almost miscarried before 12 weeks
6	Self did not want pregnancy
7	Seriously ill during pregnancy
8	Eaten/drank/smoked something harmful to baby
9	Almost miscarried after 12 weeks
10	Had contact with an infectious disease in pregnancy
11	Miscarried in past 12 months

Table 3.3.3.2 Pregnancy specific life event items

Figure 3.3.3.3 Frequency of Support Threatening Life Event Items in the Engagement Sub-Groups



ITEM NUMBER	ITEM DESCRIPTION
1	Partner not want pregnancy
2	Arguments with in-laws
3	Arguments with mother
4	Significant other died
5	Partner died
6	Arguments with partner
7	Partner was unfaithful
8	Partner told them they were no longer loved
9	Separated from partner

Table 3.3.3.3 Support threatening life event items

3.3.4 Conclusions of the comparison of the three health-promoting variables for the engagement sub-groups

Firstly, the compliant sub-group participant's were the least likely to have high internal LOC, they were most likely to perceive that their support needs were being met, and on the whole have had fewer negative life events. Secondly, the non-compliant sub-group participants were the most likely to have high powerful others LOC in combination with low chance LOC, they perceived that their support needs were not being met fully, and were more likely to have experienced support threatening life events. Finally, the refuser sub-group participants were the most likely to have high chance LOC, they also perceived that their support needs were not being met, and were the most likely sub-group to have experienced both pregnancy specific and non-pregnancy specific life events.

Therefore, whilst the engagement sub-groups are comparable demographically in the antenatal period, they do differ in terms of the three health-promotion variables investigated in this study. Thus it may be possible to identify antenatal predictive factors of engagement in health-promotion behaviour in relation to the 'Preparing for Parenthood' intervention. However, prior to the reporting of the regression analyses of the study investigating the predictiveness of these factors, the next section reports the results of the monitoring analysis which was carried out to explore the extent that internal validity could be assumed amongst the eight intervention groups run over the course of the study.

3.4 Self-rated adherence of course leaders and participant perception of their adherence to the intervention package

To ensure that the conclusions drawn from this study reflect engagement to the intervention described in the package, and are not confounded by the possibility that the course leaders interpreted and presented the intervention differently each time a set of classes was run, the adherence of the course leaders to the package was explored. The seven core themes of the intervention are shown below and were rated by the participants and course leaders on identical feedback forms at the end of each session as part of the monitoring procedure of the intervention (see the last two pages of appendix 3 for the layout of the feedback forms). The seven themes were: being given information; talking about social support; thinking about childhood experiences; looking at thoughts, beliefs, etc.; exploring hidden wishes and fears; problem solving; and finally, sharing feelings and concerns.

Of these themes, those concerned with childhood experiences and hidden wishes were “filler” items, not expected to vary across sessions. For each session, the protocol specified “main emphasis” and themes “addressed, but not the main focus of the session”. Adherence to the protocol was assessed with reference to both leader and participant ratings. Participant ratings constitute an additional test of adherence.

The scale indicating the extent to which the individual perceived the core theme as being presented within the session was: not at all (scored 0), a little (scored 1), quite a lot (scored 2), a lot (scored 3), and a great deal (scored 4). Table 4.2 shows the mean and standard error of leader and participant ratings at each session on the seven themes. It also presents the mean and standard error of the 6-point overall helpfulness ratings of each session. Entries in **bold** face refer to themes intended to be the main emphases of the relevant session; while entries in *italic* font relate to themes intended to be addressed, although not the main focus of the session. The simplest approach to assessing adherence from these complex data is to consider, for each theme in turn, how the ordering of the means across the seven sessions relates to the degree of emphasis (main emphasis, addressed but not main focus, or neither) assigned by the protocol of the package to each session.

With respect to information, leader ratings are clearly highest for the two sessions for which it was the main emphasis; participant ratings are highest for one of these sessions (session 3) whilst those of the other session (session 1) are unremarkable. With respect to support, leader ratings clearly single out the three sessions for which it was to be the main emphasis, with the lowest-rated session being the only one (session 1) for which support was not a theme. Again, participant ratings showed a weaker trend, although the two highest ratings (sessions 4 and 5) were among the three for which it was the main emphasis, and the lowest rating again being for session 1. With respect to thoughts, both leaders and participants gave high ratings to session 1 (main emphasis) and 4 (addressed but not main focus), although session 6 (main emphasis) was given a lower rating than implied in the protocol. Both leader and participant ratings of problem solving accorded well with the protocol, except for the low ratings given to the reunion session, in which it was intended that this theme be addressed although not a main focus. With respect to sharing feelings and concerns, neither leaders’ nor participants’ ratings reflected the protocol over the early sessions. However, the relatively high ratings of session 6 and of the reunion were consistent with the protocol.

In addition, the relatively uniform ratings assigned to “filler” items across sessions confirms their subordinate role in both leaders’ and participants’ experience of the sessions.

It can also be seen that there were differences between the emphases placed by the course leaders and participants. They are not great differences as they are generally in adjacent categories of emphasis (for example, ‘a lot’ as opposed to ‘quite a lot’). The direction of difference in the emphasis indicated seems to follow a pattern dependent upon the nature of the theme. The themes that were more didactic in their presentation and supported with written information (information, support, problem-solving) tended to be perceived as being emphasised more by the course leaders than the participants. Conversely, the themes that were less structured and intended for participant-guided discussion (Childhood experience, thoughts, wishes and fears) tended to be perceived as being emphasised more by the participants than the course leaders. This pattern was observable across all the sessions including the reunion.

It was also checked to see whether any theme had been consistently rated by the participants as not being covered or only touched upon during the entire course. There was no evidence of such consistent omissions. From this it was concluded that the monitoring procedure via the completion of feedback forms by both the course leaders and the participants had face validity.

In sum, this analysis of subjective assessments, albeit preliminary, suggests a considerable degree of adherence to the intervention package. Therefore, any effects found with regards to engagement are attributable to the known structure of the intervention and not to some unknown confounding factor - be it a structural, content or procedural factor. In respect of information and support, leaders’ ratings followed the protocol more clearly than did those of participants. This suggests that leaders were not entirely but were mostly successful in conveying the priorities of the package for the session to the participants.

Rater	Theme (Range of scale)	Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Reunion
Leader	Overall helpfulness of session (0 - 5)	4.0 (.13)	4.1 (.08)	4.4 (.11)	4.4 (.14)	4.2 (.15)	4.2 (.11)	4.5 (.20)
Participant	Overall helpfulness of session (0 - 5)	4.1 (.11)	4.3 (.10)	4.4 (.08)	4.3 (.11)	4.2 (.10)	4.2 (.10)	3.9 (.24)
Leader	Being given information (0 - 4)	3.1 (.22)	2.4 (.27)	3.2 (.15)	1.9 (.26)	1.3 (.14)	1.6 (.23)	1.1 (.39)
Participant	Being given information (0 - 4)	2.4 (.14)	2.6 (.16)	3.1 (.08)	2.5 (.17)	2.2 (.18)	2.5 (.20)	1.5 (.32)
Leader	Talking about social support (0 - 4)	1.1 (.16)	<i>2.1 (.24)</i>	<i>2.1 (.22)</i>	3.3 (.31)	3.0 (.17)	2.9 (.18)	<i>2.3 (.24)</i>
Participant	Talking about social support (0 - 4)	1.6 (.16)	<i>2.7 (.31)</i>	<i>2.5 (.11)</i>	3.5 (.13)	2.8 (.15)	2.7 (.18)	<i>2.5 (.23)</i>
Leader	Thinking about childhood experiences (0 - 4)	1.1 (.14)	0.6 (.26)	0.5 (.12)	0.8 (.15)	0.5 (.14)	1.0 (.25)	0.4 (.18)
Participant	Thinking about childhood experiences (0 - 4)	0.9 (.15)	0.3 (.14)	0.8 (.13)	0.6 (.19)	0.5 (.15)	0.8 (.22)	0.9 (.24)
Leader	Looking at thoughts, beliefs, etc. (0 - 4)	2.7 (.25)	2.0 (.25)	1.6 (.27)	<i>2.5 (.14)</i>	2.3 (.31)	1.9 (.20)	1.2 (.22)
Participant	Looking at thoughts, beliefs, etc. (0 - 4)	2.7 (.14)	2.2 (.17)	2.2 (.12)	<i>2.5 (.21)</i>	2.3 (.18)	2.3 (.20)	2.1 (.30)
Leader	Exploring hidden wishes and fears (0 - 4)	1.8 (.23)	1.6 (.38)	1.9 (.29)	1.5 (.23)	2.1 (.21)	2.1 (.21)	1.6 (.24)
Participant	Exploring hidden wishes and fears (0 - 4)	2.5 (.16)	2.3 (.20)	2.4 (.14)	2.0 (.20)	2.3 (.19)	2.5 (.22)	1.7 (.22)
Leader	Problem solving (0 - 4)	0.7 (.13)	3.4 (.23)	1.5 (.12)	<i>1.8 (.27)</i>	2.2 (.24)	0.9 (.07)	<i>1.1 (.20)</i>
Participant	Problem solving (0 - 4)	1.9 (.17)	3.6 (.11)	2.3 (.11)	<i>2.8 (.15)</i>	2.7 (.15)	2.3 (.19)	<i>1.3 (.30)</i>
Leader	Sharing feelings and concerns (0 - 4)	2.5 (.29)	2.4 (.29)	3.0 (.23)	2.6 (.33)	3.1 (.21)	<i>3.4 (.20)</i>	3.2 (.28)
Participant	Sharing feelings and concerns (0 - 4)	2.8 (.14)	3.2 (.17)	2.9 (.10)	3.1 (.13)	3.1 (.13)	<i>3.4 (.15)</i>	3.7 (.13)

Table 3.4 Means and (standard errors) of the intervention rated by course leaders and participants at each session.

Bold = “main emphasis of session”; italic = areas “addressed, but not main focus of session”.

3.5 Primary analysis: Investigating the antenatal characteristics of the three engagement sub-groups

Firstly, variables that may have differed in the antenatal period between the compliant and non-compliant sub-groups were investigated. Secondly, rather than exploring which factor(s) may have led to individuals self-selecting out of the intervention at the recruitment stage (the refusers) versus individuals taking the opportunity to be randomised with a view to attending the intervention (the acceptors - the control and intervention groups) as a single comparison, it was decided that the intervention and control groups were comparable (based on the results of section 3.2) and that only one of the two randomised groups need be included in the comparison. The intervention group data was used, instead of the control group data, as the engagement of the intervention group is of central importance to this thesis. Thus each of the intervention's engagement sub-groups were compared in turn with the refuser sub-group.

These analyses were carried out with a view to establishing predictive factors of engagement that could be included in a screening questionnaire.

3.5.1 Compliant vs. non-compliant

Table 3.5.1 shows the logistic regression and frequency of all those variables that were considered to differ between the engagement sub-groups of the participants. Between the compliant and non-compliant groups there were no significant results from the regression analyses. No variable achieved significance. Therefore it can not be suggested that a factor (of the variables investigated in this study) may have influenced the participants engagement in the intervention between these two groups.

VARIABLE	Odds Ratio	95% Confidence Interval	P value	Frequency in compliant sub- group n=42	Frequency in non-compliant group n=52
EPDS:	0.96	0.38 - 2.42	0.94	11	14
GHQ-D:	2.05	0.83 - 5.03	0.12	16	12
Poor Social Support:					
Good Friends	0.92	0.19 - 4.37	0.92	3	4
Close Relatives	0.59	0.14 - 2.51	0.47	3	6
Screening support Q's	0.19	0.02 - 1.62	0.13	1	6
All	0.60	0.21 - 1.67	0.33	7	13
Problem Solving:					
Confidence	1.29	0.44 - 3.80	0.64	8	8
Avoid-Approach Style	0.98	0.42 - 2.27	0.97	16	20
Personal Control	1.75	0.77 - 4.01	0.18	26	25
Locus of Control:					
Powerful Others	0.37	0.09 - 1.46	0.15	3	9
Chance	1.30	0.57 - 2.99	0.53	18	19
Internal	0.80	0.34 - 1.89	0.61	27	36
Life events:					
Non-pregnancy specific (LTE)	0.95	0.40 - 2.23	0.91	27	34
Pregnancy Specific	0.98	0.43 - 2.21	0.96	20	25
Support Threatening	0.81	0.36 - 1.83	0.61	18	25
General Difficulties	2.56	0.78 - 8.34	0.12	9	5
Dissatisfaction with Housing	1.24	0.07 - 20.50	0.88	1	1
Service Contact	1.06	0.42 - 2.70	0.89	11	13

Table 3.5.1 - Logistic regression of all variables at baseline by group (compliant vs. non-compliant). P<0.05 *, P<0.01 **

3.5.2 Compliant vs. refuser

Table 3.5.2 again shows the logistic regression and frequency of all those variables that were considered to differ between these engagement sub-groups of the participants. Between the compliant and refuser groups there was only one significant result from the regression analyses. The women who decided not to have the opportunity to attend the intervention and so were not randomised (refusers) had had less contact with the NHS in the time prior to the baseline assessment than the women who eventually were allocated to the intervention and did attend (compliant) (P = 0.04, odds ratio = 2.77, 95% confidence interval 1.07 - 7.17). No other variable achieved significance. Therefore, it can be suggested that a factor influenced the participants potential engagement in the intervention between these two groups and this factor could be incorporated in a screening measure to predict degree of engagement in the intervention.

VARIABLE	Odds Ratio	95% Confidence Interval	P value	Frequency in compliant sub-group n=42	Frequency in refuser sub-group n=88
EPDS:	1.00	0.43 - 2.31	0.99	11	23
GHQ-D:	1.25	0.58 - 2.69	0.56	16	29
Poor Social Support:					
Good Friends	0.54	0.14 - 2.04	0.36	3	11
Close Relatives	1.28	0.29 - 5.62	0.75	3	5
Screening support Q's	0.40	0.04 - 3.58	0.41	1	5
All	0.78	0.29 - 2.04	0.60	7	18
Problem Solving:					
Confidence	0.98	0.38 - 2.50	0.97	8	17
Avoid-Approach Style	0.56	0.26 - 1.19	0.13	16	46
Personal Control	1.07	0.50 - 2.28	0.85	26	53
Locus of Control:					
Powerful Others	0.67	0.17 - 2.63	0.57	3	9
Chance	0.72	0.34 - 1.50	0.38	18	45
Internal	0.80	0.37 - 1.73	0.57	27	61
Life events:					
Non-pregnancy specific (LTE)	1.19	0.55 - 2.55	0.66	27	53
Pregnancy Specific	0.63	0.30 - 1.32	0.22	20	52
Support Threatening	1.31	0.62 - 2.77	0.48	18	32
General Difficulties	1.23	0.49 - 3.06	0.66	9	16
Dissatisfaction with Housing	0.40	0.04 - 3.58	0.42	1	5
Service Contact	2.77	0.60 - 4.01	0.04 *	11	10

Table 3.5.2 - Logistic regression of all variables at baseline by group (compliant vs. refuser).

P<0.05 *, P<0.01 **

3.5.3 Non-compliant vs. refuser

Finally, table 3.5.3 shows, once again, the logistic regression and frequency of all those variables that were considered to differ between these engagement sub-groups of the participants. Between the non-compliant and refuser groups there was only one significant result from the regression analyses. Again it was found that the women who decided not to have the opportunity to attend the intervention and so were not randomised (refusers) had had less contact with the NHS in the time previous to the baseline assessment than the women who eventually were allocated to the intervention and did attend (compliant) ($P = 0.04$, odds ratio = 2.60, 95% confidence interval 1.05 - 6.45). No other variable achieved significance. Therefore, it can be suggested that a factor influenced the participants potential engagement in the intervention between these two groups and this factor could be incorporated in a screening measure to predict degree of engagement in the intervention.

VARIABLE	Odds Ratio	95% Confidence Interval	P value	Frequency in non-compliant group n=52	Frequency in refuser sub-group n=88
EPDS:	1.04	0.48 - 2.26	0.92	14	23
GHQ-D:	0.61	0.28 - 1.34	0.21	12	29
Poor Social Support:					
Good Friends	0.58	0.17 - 1.94	0.38	4	11
Close Relatives	2.16	0.63 - 7.48	0.22	6	5
Screening support Q's	2.16	0.63 - 7.48	0.22	6	5
All	1.29	0.57 - 2.92	0.53	13	18
Problem Solving:					
Confidence	0.76	0.30 - 1.90	0.55	8	17
Avoid-Approach Style	0.57	0.28 - 1.15	0.11	20	46
Personal Control	0.61	0.30 - 1.22	0.16	25	53
Locus of Control:					
Powerful Others	1.84	0.68 - 4.97	0.23	9	9
Chance	0.55	0.27 - 1.11	0.09	19	45
Internal	0.99	0.47 - 2.09	0.99	36	61
Life events:					
Non-pregnancy specific (LTE)	1.25	0.61 - 2.54	0.54	34	53
Pregnancy Specific	0.64	0.32 - 1.28	0.20	20	52
Support Threatening	1.62	0.80 - 3.25	0.17	25	32
General Difficulties	0.48	0.16 - 1.39	0.18	5	16
Dissatisfaction with Housing	0.32	0.04 - 2.86	0.31	1	5
Service Contact	2.60	0.61 - 3.76	0.04 *	13	10

Table 3.5.3 - Logistic regression of all variables at baseline by group (non-compliant vs refuser). P<0.05 *, P<0.01 **

3.5.4 Conclusions of the primary analysis

It would appear that a factor may have influenced the participants potential engagement in the intervention between the engagement sub-groups. However, it was not one of the three variables thought to influence health-promoting behaviour. The women who declined to be randomised (refusers) had significantly less contact with the NHS in the time prior to the baseline assessment than either the compliant or the non-compliant participants (which in combination form the intervention group, this group is in turn is equivalent to the control group and, therefore, the acceptor population of the study at the recruitment stage). Unfortunately, no significant differences were found between the compliant and non-compliant groups. Therefore, further planned analyses to clarify the critical components of the three health-promoting variables that act as simple predictors of engagement were unnecessary.

3.6 Secondary analysis: Investigating the postnatal impact of the intervention upon the factors influencing health-promoting behaviour

The three variables thought to influence health-promoting behaviour were then analysed, with the other variables investigated of relevance to the study, to investigate whether they may have differed between the compliant and non-compliant groups as a result of attending the intervention.

3.6.1 Intervention vs. control

Table 3.6.1 shows the logistic regression and frequency of the variables in the study, including the variables thought to influence health-promoting behaviour, that allocation to and intended attendance of the intervention may have effected in the first three months of the postnatal period. Between the two intention-to-treat (intervention and control) groups there were two significant results from the regression analyses. Firstly, there were more women who had an avoidant problem-solving style in the intervention group than in the control group at 3 months postnatally, a ratio of 45 to 28 ($P = 0.008$, odds ratio = 2.23, 95% confidence interval 1.22 - 4.05); and secondly, there were more women who had a high belief in the control of powerful others (in this case medical professionals) in the intervention group than there were in the control group at 3 months postnatally, a ratio of 10 to 2 ($P = 0.029$, odds ratio = 5.59, 95% confidence interval 1.19 - 26.26). No other variable achieved significance. Therefore it may be suggested that the allocation to and intended attendance of the intervention per se had an impact upon these factors, one of which is part of a variable thought to promote healthy behaviour.

VARIABLE	Odds Ratio	95% Confidence Interval	P value	Frequency intervention group n=94	Frequency control group n=96
Poor Social Support:					
Good Friends	999.0	0 - Infinity	0.96	1	0
Close Relatives	0.84	0.25 - 2.86	0.78	5	6
Screening support Q's	1.24	0.36 - 4.21	0.73	6	5
All	1.26	0.51 - 3.07	0.61	12	10
Problem Solving:					
Confidence	0.69	0.25 - 1.90	0.47	7	10
Avoid-Approach Style	2.23	0.78 - 2.58	0.008 **	45	28
Personal Control	1.13	0.64 - 2.00	0.67	47	45
Locus of Control:					
Powerful Others	5.59	0.45 - 9.97	0.03 *	10	2
Chance	1.03	0.54 - 1.93	0.93	27	27
Internal	0.96	0.54 - 1.69	0.88	45	47
Life events:					
Non-pregnancy specific (LTE)	1.35	0.75 - 2.40	0.31	42	36
Pregnancy Specific	0.54	0.25 - 1.14	0.11	13	22
Support Threatening	0.93	0.50 - 1.73	0.83	28	30
General Difficulties	0.16	0.01 - 1.36	0.09	1	6
Dissatisfaction with Housing	0.50	0.08 - 2.79	0.43	2	4
Service Contact	1.24	0.52 - 2.92	0.62	13	11

Table 3.6.1 - Logistic regression of all variables at 3 month outcome by group (control vs. intervention). P<0.05 *, P<0.01 **

3.6.2 Compliant vs. non-compliant

Again table 3.6.2 shows the logistic regression and frequency of the variables in the study, including the variables thought to influence health-promoting behaviour, but this time to reflect whether *actually attending* or *not attending* the intervention per se may have an effect that lasts into the first three months of the postnatal period. However, between the compliant and non-compliant groups there were no significant results from the regression analyses. No variable achieved significance. Therefore it can not be suggested that any factor investigated may have been influenced by the actual attendance or non-attendance of the intervention.

VARIABLE	Odds Ratio	95% Confidence Interval	P value	Frequency in compliant sub- group n=42	Frequency in non-compliant group n=52
Poor Social Support:					
Good Friends	0.00	0 - Infinity	0.96	1	0
Close Relatives	1.22	0.19 - 7.68	0.83	2	3
Screening support Q's	1.67	0.29 - 9.57	0.57	2	4
All	1.15	0.33 - 3.92	0.82	5	7
Problem Solving:					
Confidence	1.08	0.23 - 5.13	0.92	3	4
Avoid-Approach Style	1.72	0.75 - 3.90	0.20	17	28
Personal Control	1.68	0.74 - 3.82	0.21	18	29
Locus of Control:					
Powerful Others	2.02	0.49 - 8.35	0.33	3	7
Chance	0.82	0.33 - 2.01	0.67	13	14
Internal	1.21	0.53 - 2.73	0.65	19	26
Life events:					
Non-pregnancy specific (LTE)	0.57	0.25 - 1.29	0.18	22	20
Pregnancy Specific	1.34	0.40 - 4.46	0.63	5	8
Support Threatening	1.37	0.55 - 3.36	0.49	11	17
General Difficulties	0.00	0 - Infinity	0.96	1	0
Dissatisfaction with Housing	0.80	0.05 - 13.25	0.88	1	1
Service Contact	0.65	0.20 - 2.11	0.48	7	6

Table 3.6.2 - Logistic regression of all variables at 3 month outcome by group (compliant vs. non-compliant). P<0.05 *, P<0.01 **

3.6.3 Conclusions of the secondary analysis

It would appear that two additional factors differed between the randomised groups such that women allocated to and intended attendance of the intervention group were both more likely to avoid their problems, and have a high belief in powerful others. However, when the intervention group was broken down by actual attendance, these differences were no longer present. This implies that the differences seen were unlikely to be due to any effect of the intervention and that attendance of the intervention itself did not have any impact on the variables thought to influence health-promoting behaviour.

4 Qualitative Study Method

In order to explore the appeal and success of the intervention as perceived by the participants, an additional set of intervention classes was organised to investigate the issue of engagement in the intervention using qualitative methods. This ensured that the randomised control trial design, which used purely quantitative methods, was not compromised by the additional interviews. The procedures for the qualitative study corresponded to those of the core trial study, in particular, the intervention was identical in both studies so that comparisons could confidently be made.

4.1 Design

Young mothers in their first pregnancy and due to have their baby in February, March, or April 1998 were screened to identify women at risk of postnatal psychiatric depressive disorder. Those who were at high risk were invited to receive the brief focused intervention designed to reduce deficits in social support 'Preparing for Parenthood'. These high risk women were then interviewed when their baby was 2 - 3 months old to explore their experiences of the study and the intervention. See figure 4.1.

Ethical approval was obtained from Leicestershire Health Authority for the study in November of 1997 (ref. 4871).

4.2 Eligible Patients

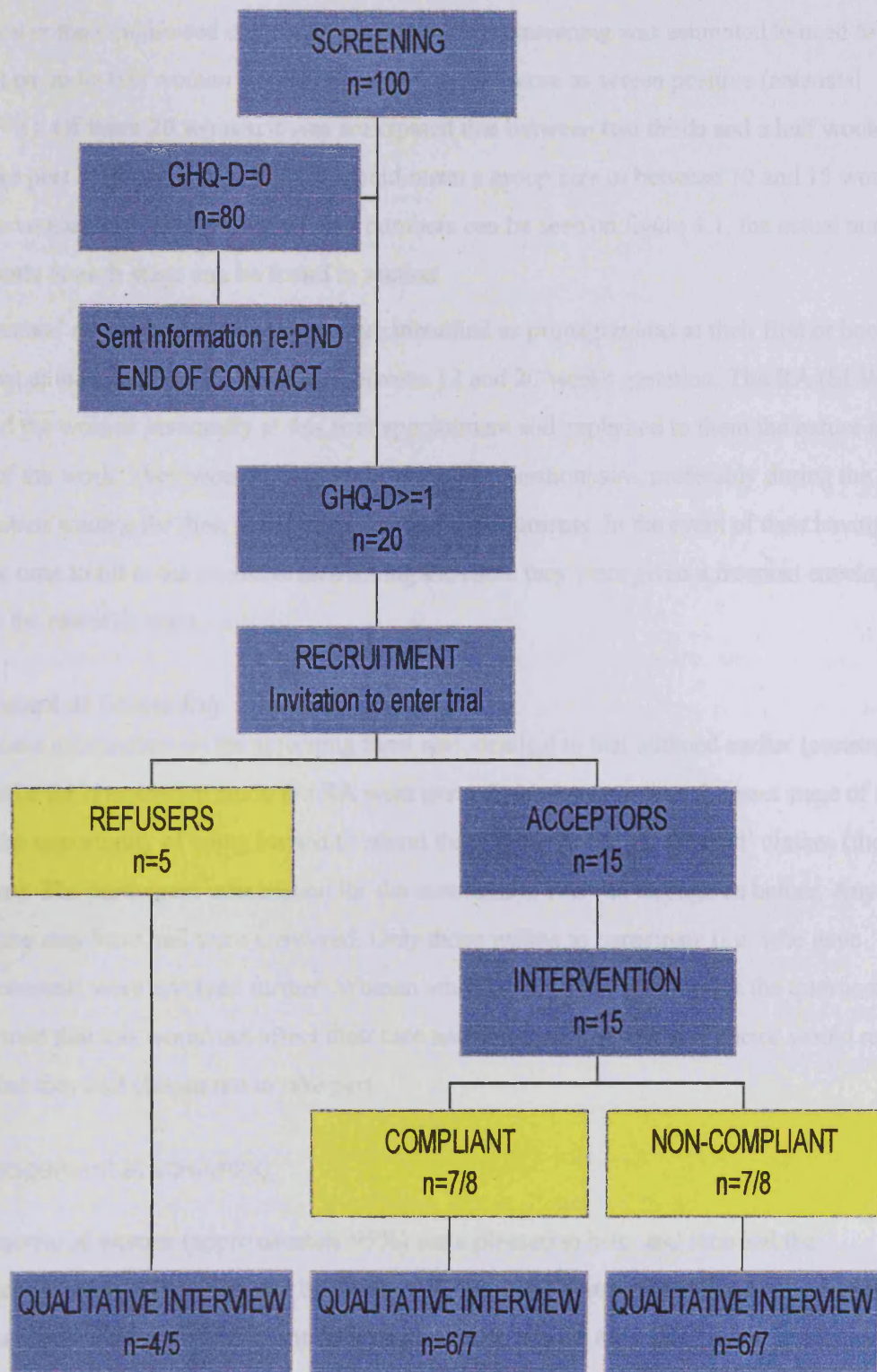
For entry into the study, each woman had to be:

1. at least 16 years of age at booking for obstetric care,
2. in a first pregnancy that she planned to continue to full term,
3. residing within reasonable travelling distance of the base hospital (with no intention of moving significantly far away for at least the first 3 months of the life of her baby),
4. capable of understanding and completing screening questionnaires in the English language,
5. and without any dependants (for example, step children).

4.3 Procedural differences from the quantitative study

The procedure followed that of the quantitative study as far as possible, and where appropriate. For instance, the same screening method and psychosocial intervention package were included. However, there was no need to carry out either a baseline assessment nor an outcome assessment since quantitative data were not collected in this exploratory study.

FIGURE 4.1 QUALITATIVE STUDY DESIGN
(with *predicted* numbers of participants)



4.4 Selection screening

As in the quantitative study all women attending their first antenatal clinic were screened using the same questionnaire. As in our previous cohort study in the same antenatal clinic, Brugha *et al.* (1998), it was predicted that 15-20% would be identified as at high risk, consenting and eligible for inclusion in the randomised controlled trial. Therefore, screening was estimated to need to be carried out on up to 100 women so that 20 women would score as screen positive (antenatal GHQ-D \geq 1). Of these 20 women it was anticipated that between two thirds and a half would want to take part in the intervention. This would mean a group size of between 10 and 15 women for the intervention classes. These predicted numbers can be seen on figure 4.1, the actual number of participants at each stage can be found in section

Via antenatal medical records women were identified as primagravidas at their first or booking appointment at the clinic, when they were between 12 and 20 weeks gestation. The RA (SLW) approached the women personally at this first appointment and explained to them the nature and purposes of the work. They were invited to complete the questionnaire, preferably during the clinic, between waiting for their scan and consultant appointments. In the event of their having insufficient time to fill in the questionnaire during the clinic they were given a freepost envelope to return it to the research team.

4.4.1 Consent at Screening

The patient information on the screening form was identical to that outlined earlier (section 2.4.1). Unlike the quantitative study the RA went immediately on to outline the next stage of the study i.e. the opportunity of being invited to attend the 'Preparing for Parenthood' classes (the intervention). The participant information for the intervention was run through as before. Any questions she may have had were answered. Only those willing to participate (i.e. who gave informed consent) were involved further. Women who preferred not to complete the questionnaire were informed that this would not affect their care and that their midwife and doctor would remain unaware that they had chosen not to take part.

4.4.2 Engagement at screening

The majority of women (approximately 95%) were pleased to help, and returned the questionnaire promptly. However, for the minority, a reminder system was operated that followed the same set procedure as for the quantitative study. Most women then posted the questionnaire

back within a week; a few had decided not to complete it and declined to take any further part in the study.

4.4.3 Selection at screening

Once the questionnaires were returned, they were allocated a participant number, and scored for GHQ-D. Social support scores were not calculated as they were not required for this particular study. The 'top sheet' containing the demographic information i.e. name, address, and telephone numbers of the participant was removed and stored separately from the now anonymised questionnaire data. The data from those individuals identified as 'screen positive' (at increased risk of developing postnatal depression, $\text{GHQ-D} \geq 1$) were collated ready for contact to be made at the next stage. Data on all the women who were not identified as depressed (i.e. questionnaires that were scored negative $\text{GHQ-D} = 0$) were stored separately. Unlike the quantitative study, these women were sent information drawn from the intervention on postnatal depression 1 month after they had returned their completed questionnaire which also informed them that they would not, unfortunately, be invited to join the 'Preparing for Parenthood' classes.

4.5 Invitation to the intervention

To avoid the eventuality that a woman might be contacted for an interview who was no longer pregnant, the same system with the antenatal medical record team was set up to notify the research team if this occurred.

4.5.1 Initial contact

Those women who had scored one or more on the GHQ-D section of the screening questionnaire were contacted by telephone approximately one month after their completed questionnaires were returned. The women were invited to attend the 'Preparing for Parenthood' classes. After establishing there was an interest in the classes, the RA went on to inform them of the dates and times of the classes, their location within the Leicester General hospital, and the possible times of their initial meetings. They were also told that they did not have to make a decision immediately and could discuss it with their partner / mother / friends / place of work before making up their mind - the RA would contact them again in a couple of days time. The majority of women made a decision at the initial telephone contact.

4.5.2 Outcome of the invitation

Upon obtaining her decision regarding the invitation to attend the intervention, a standard procedure was followed. If she had decided against attending 'Preparing for Parenthood', she was told that we would like to contact her again when her baby was 3 months old and asked if this would be acceptable. These participants are referred to as 'refusers' - they have declined the intervention but have expressed an interest in future follow-ups.

If she decided to accept the invitation to attend the intervention, the RA made an appointment time for the initial meeting with the course leaders and arrangements were made to send two copies of the letter containing all the relevant information about the times, dates and location of the classes - one copy for her and one for her employer (if she was employed). Out of the 20 women approached, 16 wanted to take part in the intervention.

If the participant was uncontactable by telephone a letter was sent asking her if she would like to have the opportunity to attend the 'Preparing for Parenthood' classes. A freepost envelope was enclosed for her reply. All women were contacted at this stage, the majority by telephone.

4.6 Intervention

The intervention was carried out following exactly the same procedures as for the core trial study and was run by course leaders drawn from the same pool. The only difference was that this particular set of intervention sessions were video taped for a parallel study exploring the adherence of course leaders to the intervention package and the interactions amongst the women group members with each other and the course leaders. The results of this study will not be reported here. The supportive intervention package 'Preparing for Parenthood' is described in detail in chapter 2. Procedural issues are covered elsewhere, see section 2.7.4.

4.7 Postnatal qualitative interview

The entire sample of women who had scored positive on the screening questionnaire was divided in half as two separate qualitative studies were to be conducted, one by the author and one by another researcher. Of the three sub-groups of the sample, 4 met the criteria for 'compliant' (as defined in the core study as having attended session 3 and at least two other sessions), 11 were 'non-compliant' (did not attend session 3 and attended any other of the five possible sessions), and 4 were refusers.

4.7.1 Initial contact

All participants, compliant, non-compliant and refusers were contacted by post between one and two months postnatally, again in expected delivery date month batches. The letter explained that regardless of whether or not they had managed to come along to the classes, their experiences of the research project were of value to us and would help us to monitor and improve our research methods. The letter also informed them that the interview would be audiotaped for the use of the research team only. They were told that the researcher would be contacting them within the next week to arrange a date and time for them to be visited at home if this was convenient.

4.7.2 Arranging the Interview

Upon telephoning the participants it was established whether they were agreeable to being interviewed or not. If they were not interested then they were thanked for their help with the study to date. Only one woman out of the eleven possible participants declined due to personal difficulties. She was a member of the refuser sub-sample.

For those women who were interested in being interviewed about their experiences of the study, it was arranged to see them at home when their baby was between two and three months old (calculated using their estimated due dates from their screening questionnaires).

4.7.3 Consent at interview

Due to the open question structure of the interview it was necessary to use audio tape recording equipment to record the participants responses and the interviewers' questions. The participant women were told that the interview would feel more like a conversation and that they should be completely honest in their opinions. Written, informed, consent was sought and obtained for all women at this stage prior to the interview commencing.

4.8 Qualitative interview questions

The interview consisted of 9 questions constructed to explore fully the core areas of interest within this study. The questionnaire was designed bearing in mind the form of qualitative analysis to be used i.e. Grounded theory. Generally the questions were asked in the order in which they appear on the interviewer's guide sheet. However, if a participant answered a question prior to its being asked it was simply discussed fully at that point and not delayed until later in the interview. The core questions are shown below. The interviewers guide sheet is shown in appendix 2.

Questions:

1. When you received the Pregnancy & You questionnaire, why did you think you were being asked to help us?
2. Did you talk to anyone about deciding whether or not to attend the classes?
3. What did you take into consideration when deciding if the classes were for you? e.g. content, location, timing, travel.
4. What had you heard about postnatal depression before I spoke to you in the antenatal clinic?
5. The thought of postnatal depression - that you might be that one woman in ten - how did that make you feel?
6. Looking back, do you think you (would have) enjoyed the classes?
7. Did you go to the classes run by the midwives?
 Yes - What did you think of the classes?
 No - Why didn't you go to the classes?
8. If you could turn the clock back to when I saw you when you were pregnant, would your decision to attend or not attend the 'Preparing for Parenthood' classes be different now?
9. If there was one thing - anything - that you could change to improve the classes what would it be?

4.9 Preparation for analysis

The interviews were transcribed from the audio-tapes and each of the participants' responses numbered. The themes salient to each individual were identified as a first step and then the entire sample's main themes were pooled to gain an overall picture of the participant's experiences of the intervention.

5 Qualitative study results

5.1 Qualitative study sample: dispersal and attrition

The Figure 5.1 illustrates the structure of the study, the dispersal of the sample over the period of investigation and the actual attrition encountered.

5.2 Description of sample to be interviewed

The women varied in age from 16 to 31 years old at the onset of the study, were mostly married or cohabiting (there was only one single status participant), had completed between 11 and 16 years full-time education, and all but one were in either full-or part-time employment. The table of the data illustrating the full demographic description of the sample is not included in this section in order to continue to maintain confidentiality. This information is available upon written request from the author. The names of participants have been changed with their agreement.

Of the twelve women identified for interview by the researcher SLW, one interview was declined and two others were not completed (one due to personal problems, and another due to the participant having a sensory impairment).

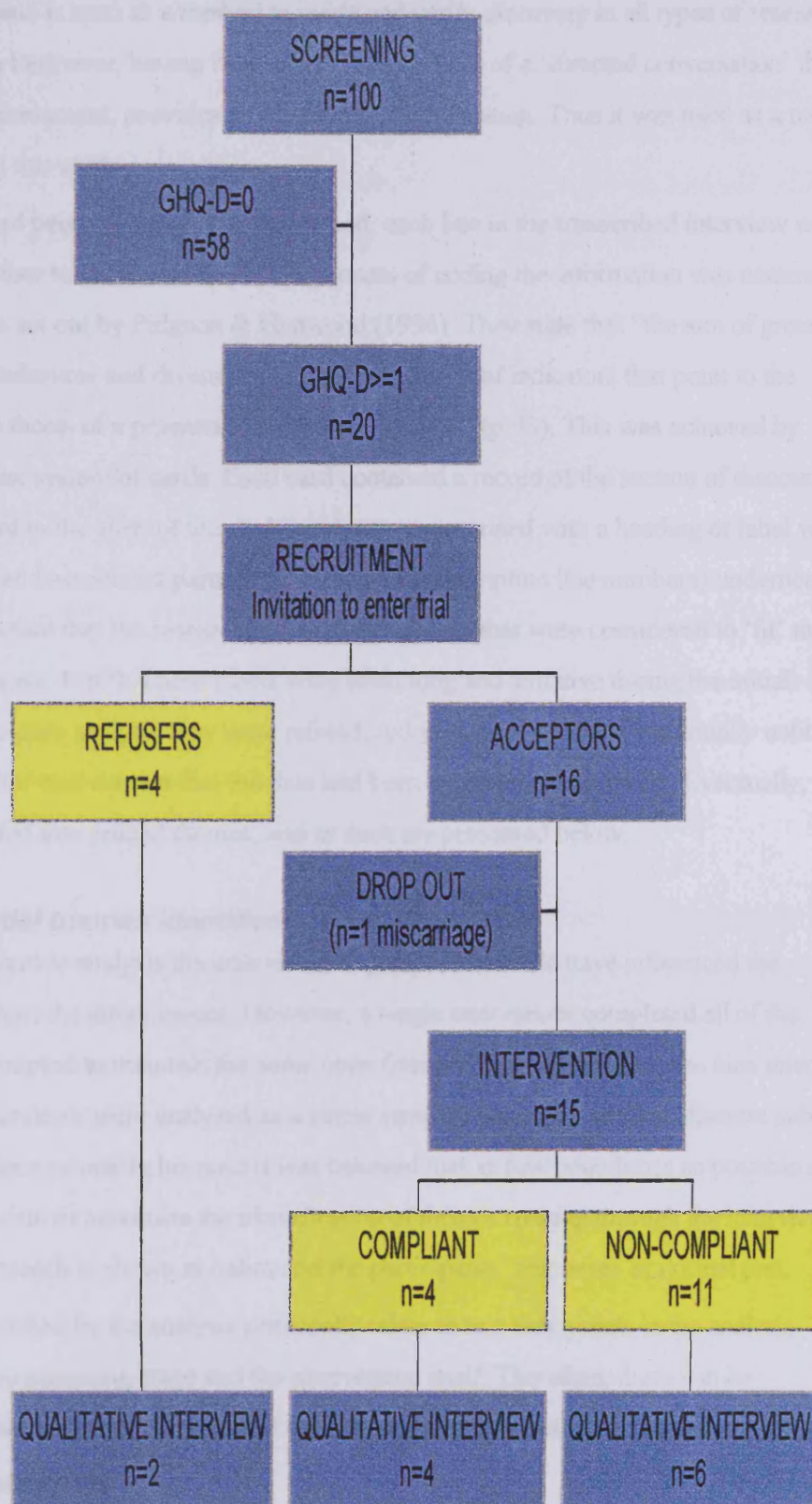
5.3 Emotional well-being of sample to be interviewed

The table below shows the GHQ-D and EPDS scores of the women in the sample over the study period (where available i.e. if they came to that session, N/A = non-attendance for that session). From the table it can be seen that the participant women's emotional well-being fluctuated across their pregnancies and by the end of the intervention the women who attended the final session appeared to have measurably increased vulnerability to postnatal depression.

Name & number	Sub-sample	Screening GHQ-D	Initial meeting EPDS	Session 6 EPDS
Emma	Compliant	2	10	17
Helen	Compliant	2	8	6
Claire	Compliant	1	3	9
Ameena	Compliant	1	6	11
Samantha	Non-compliant	1	9	N/A
Tanya	Non-compliant	2	9	N/A
Sarah	Non-compliant	1	16	N/A
Michelle	Non-compliant **	1	N/A	N/A
Rachel	Non-compliant	1	N/A	N/A
Pritty	Non-compliant **	2	N/A	N/A
Catherine	Refuser **	2	N/A	N/A
Sadie	Refuser	1	N/A	N/A

Table 5.3 Emotional well-being of the qualitative study sample

FIGURE 5.1 QUALITATIVE STUDY ATTRITION
(with *actual* numbers of participants)



5.4 Grounded Theory Analysis

The grounded theory approach involves collecting material from a variety of sources, not simply interviews, and is seen as a method to guide and verify discovery in all types of research areas. The research interview, having been carried out as more of a 'directed conversation' than a closed controlled assessment, provides a rich source of information. Thus it was used as a method of data collection in this study.

Once the data had been collected and transcribed, each line in the transcribed interview was labelled with a number to aid the analysis. The process of coding the information was commenced using the guidelines set out by Pidgeon & Henwood (1996). They state that "the aim of grounded theory is to seek similarities and diversities, collecting a range of indicators that point to the multiple qualitative facets of a potentially significant concept" (p.93). This was achieved by constructing an index system of cards. Each card contained a record of the section of discourse identified as relevant to the aims of the study, and was summarised with a heading or label with illustrative quotes (and associated participant name and transcription line numbers) underneath for clarity. It was important that the researcher constructed labels that were considered to 'fit' the data well (Glaser & Strauss, 1967). These labels were often long and tentative during the initial analysis. During the core analysis they were refined, reduced, and redefined continually until such time as the researcher was content that the data had been explored exhaustively. Eventually, the labels were integrated into related themes, and as such are presented below.

5.5 Main influential themes identified

As with all qualitative analysis the interviewers' perspective could have influenced the responses gained from the interviewees. However, a single interviewer completed all of the interviews, and attempted to maintain the same open frame of mind throughout the nine interviews completed. The interviews were analysed as a single sample rather than as three discreet sub-groups. This was done primarily because it was believed that as few boundaries as possible should be imposed on the data to maximise the identification of themes running through the interviews. The interviewers' speech is shown in italics and the participants' responses as normal text.

The themes identified by the analysis principally relate to two time points in the analysis. The themes cluster at the screening stage and the intervention itself. Therefore, these can be categorised as themes that are (a) influential for initiating engagement to the classes and (b) for maintaining that engagement.

5.5.1 Initiating engagement

Engagement can be increased by making the classes more appealing at the initial point of contact with the women. The following are the main themes that were identified as factors that could be altered to improve engagement.

5.5.1.1 Individual assessment of need for information about postnatal depression

The majority of women knew very little if anything at all about PND. There was no discernible difference between the three engagement sub-samples of compliant, non-compliant and refuser.

So you had heard about postnatal depression, and you had a bit of experience with your sister. Did you know kind of what symptoms to look for ?

No.

You'd just kind of heard of the name?

That's right.

(Emma, compliant, responses 63 - 64)

What had you heard about postnatal depression, before I spoke to you in the antenatal clinic. Had you heard of it?

Yes I had heard of it. But I didn't know that much really, I knew what to look out for in myself, but I didn't have much information. Mostly from magazines and that.

(Tanya, non-compliant, response 31)

What had you heard about postnatal depression, before I spoke to you in the antenatal clinic?

I heard you just get upset, you roar over anything, stuff like that.

What do you mean by roar ? cry?

Yeah, cry, get depressed over the slightest thing

(Sadie, refuser, responses 52 - 53)

Many women knew very little about PND and were aware of this knowledge gap. Their perception of their need for information about PND seems to have been a preoccupation with most of them at some point in their pregnancy, whether they went on to seek information or avoid it. A dichotomy of the women's perceptions of what their lack of knowledge would mean to them became clearly apparent. The two concepts with their associated themes are described below. Unfortunately, the number of illustrative quotes would be too large to accommodate in this section.

1. Lack of knowledge = protective factor: Generally, these women avoid information, see it as not tempting fate, and hope it won't happen. They did not give the impression of having control of their emotions and did not seem to want the responsibility of the potential consequences of having control of their emotions.

2. **Lack of knowledge = vulnerability factor:** Generally, these women felt exposed, they felt they were at risk of losing control of their emotions and feared not having control. They actively sought support from significant others and from individuals with previous experience of the situation they were currently experiencing. Specifically, they wanted facts and strategies for coping with every eventuality.

This can be seen below as some women sought information about postnatal depression. However, the majority of the women interviewed admitted to avoiding information about postnatal depression.

The thought of postnatal depression, that you could be that one woman in ten, how did that make you feel?

I didn't think it was too unrealistic to be honest, because of how I felt at the time. But, I obviously wanted to avoid it.

Yes.

So, I wanted to do something about it. It wasn't there at that stage, but I thought it was a possibility if I carried on thinking the way I was thinking. Not being able to shift it or see things in a different light. So I had to do something about it.

(Helen, compliant, responses 52 - 53)

So why did you want to know about postnatal depression ?

Errmm, well, basically, so that I didn't get it, you know....

And did you think about it, that you might get it?

Errmm, I didn't think I was going to get it. No, no. I just wanted to read about it

(Claire, compliant, responses 15 - 16)

I try to never let it cross me mind really 'cos I always thought well I want this baby so surely I won't get it, so I never really thought

What, you tried not to think about it?

Yeah, I think that was it

So you went out of your way not to

Yeah I think that was it, like I say I never asked about it so .. You don't want it to happen do you so you think well you'll just forget about it, I think that's what I did really

(Samantha, non-compliant, responses 64 - 68)

Did you find out anything more about postnatal depression, from you doctor or your midwife?

Well no not really. I just didn't want to know. I think I thought if I didn't know about it, it wouldn't happen [laughs]

That it would go away?

Yeah, yeah [little laugh again] Silly really

(Tanya, non-compliant, responses 35 - 36)

The individual's perception of their need for information about postnatal depression seemed to be influenced by previous contact with someone who had suffered from postnatal depression. If

their knowledge of postnatal depression was experience-based (usually from contact with one individual), the woman's perception of postnatal depression was very specific and inflexible, based almost entirely on the experiences of the woman known to them. They seemed to think they had all the information they needed as they valued information from a personal experience of postnatal depression more than media information about postnatal depression. This group of individuals did not necessarily avoid additional information but it is important to note that they were more reluctant to seek it and as such may be less likely to want to attend classes to learn about it.

On the contrary, if the individual's knowledge of postnatal depression was media-based they seemed to realise that symptoms vary from person to person, and they are more open to information about postnatal depression in general. As such they were more likely to want to attend classes to learn about it. This theme was found in women falling into both the protective and vulnerable categories of their perception of the lack of knowledge concept and is therefore described separately.

Did you actually want to know about postnatal depression - how you'd feel or how you might change?

I think I'd have liked to know about postnatal depression, but I suppose because I had first hand experience with my brothers wife...

(Rachel, non-compliant, response 39)

The only woman to place no value on the classes was in fact the refuser. However, later in the interview she appeared to have changed her mind. She went on to say what she felt she had missed out on, and what she wished she had been told about pregnancy, and how she would feel when she had her baby. Interestingly, these thoughts and feelings are precisely those which the intervention was designed to address. The contents of the classes either weren't communicated adequately at the initial contact in the antenatal clinic with the screening questionnaire, or simply were not salient to this woman at that time.

You weren't too sure. Why weren't you too sure ?

I think, you feel, like, a bit strange walking into a room full of people who know each other , where you don't , I don't think it would have made any difference

So... You don't think it would have made any difference at all?

No

So, learning about coping, support, the birth, things like that... ?

No

(Sadie, refuser, responses 19-21)

OK...If you could turn the clock back to when I saw you in the antenatal clinic, would your decision to attend or not attend our classes (Preparing for parenthood) be different now? Would you decide you didn't want to go?

I would go. I wish I could turn the clock back. Yeah.

Oh, and why's that?

Yeah learn sort of more about, know what to, I weren't sure what I was doing, being pregnant was all about.

Can you think of questions you would have liked to have answered?

What to expect....

(Sadie, refuser, responses 100-102)

5.5.1.2 Non-perpetuation of the PND taboo

The women trusted what they had read on the covering letter i.e. that they were being approached because they were a 'first-time mum'; they got involved because they wanted to help 'women coming after me' - which was what they were told by the researcher.

However, when they were given the questionnaire and the leaflet about the classes they were told only some would be invited to the classes. They were not told what the basis for selection was but were told the primary aim of the intervention was to reduce the likelihood of PND. This seems to have produced a 'why me?' syndrome. The implication was that selection was in fact based upon an increased *likelihood* of getting PND. The women were left wondering about 'hidden agendas'. This could have been avoided by being more informative about screening for low mood in pregnancy. The women knew they were low in mood as they told us this on the self-report screening questionnaire. Therefore, in future studies, providing them with the facts *sensitively* should not induce too much fear when they are invited to attend the classes. It may, in fact, increase engagement as they would have been made aware they need help.

I think it was because I was a first time mum and that was what I read on the sheet. Apart from that I don't really know why I was picked... I think the letter explained most things really... No, I didn't wonder.

(Emma, compliant, response 28)

So that we can help other women

Yeah, did you wonder why you were being asked?

No, I just thought it was for, to help, other people you know, coming after you

(Sarah, non-compliant, responses 9-10)

What kind of things did you discuss (with her partner) ?

Ermm, whether there was any hidden agenda behind it. [laughs]

Well, yeah

Obviously. And whether it would benefit me, really. And the fact that we thought it would do was the main reason we decided to do it.

(Emma, compliant, response 33-34)

5.5.1.3 Enhancing the decision-making process

This was envisaged as having been guided by the participant leaflet and what women had been told by the researcher in the clinic. However, it was hindered by the fact that many women did not read the leaflet. They wrongly assumed that it would repeat the information provided in the antenatal classes run by the midwives, though these are in fact more practical and birth oriented. A better strategy in future might be to go through the leaflet with the women in the clinic in the same way as for the questionnaire and accompanying letter.

Those who had read the leaflet could not remember its content. This may be due to the women having received a great deal of information at their first point of contact with both the research and the hospital. They may have been overloaded and found the information difficult to absorb. A further improvement might be to send a more detailed version of the leaflet at the point when the women knew that they had been selected, and at the point when they are therefore thinking about whether to attend.

When you gave me the leaflet and that I didn't really look at it, I just thought at the time, it would be showing you how to bath them or you know about feeding
(Samantha, non-compliant, response 32)

Do you remember the orange coloured leaflet I gave you, with the questionnaire, the one that was about so big and folded in half?

Yeah

Yeah. Did you actually read through it, do you remember ?

Not sure. I think I did but I forgot what I read

(Sadie, refuser, responses 45 - 46)

5.5.1.4 Various practical themes

Four practical themes were identified from the data relevant to the initial engagement of the participants. These were: the time of day, the location, the content, and the possibility of bringing along a significant other to the intervention.

5.5.1.4.1 Time of day

The research team expected problems with employers' being reluctant to release the participants from work, as the intervention was held in the morning. However, in the event, this did not occur. The majority of participants expressed the view that they welcomed morning sessions, though a mid to late morning start might have been better.

Yeah, that was the only problem that I had. I can never be one hundred percent sure what time to leave in the mornings ... just depends on the traffic. That was the only problem with it being ten o'clock. I think if it was a bit later then it would have been better
(Emma, compliant, responses 47 - 48)

5.5.1.4.2 Location

They liked that the sessions were held in the hospital as they could get familiar with the maternity unit before they came in to have their baby, but most women also commented that the classes would have been more convenient if they had been located closer to their homes. The major problem with the location was transport, even for those who did attend the sessions.

I did think it was quite nice if you got used to going to the hospital, and it wasn't such a strange place when you did come to go into labour and I knew my way around a bit because I'd been for the classes. So it wasn't such a strange experience, I was quite confident where things were
(Sarah, non-compliant, response 71)

Getting from work as well to Leicester, and I mean traveling on a bus you have to go into the town centre and then get the bus the to the Leicester General, you know, and I don't know Leicester very well.
(Samantha, non-compliant, response 46)

So it would, basically, be easier for you to actually come to classes that were local ?

Yeah, yeah

That's really it, isn't it, although it wasn't a problem this time, it would ...

It would be better if, yeah, they were local

(Samantha, non-compliant, responses 48 - 49)

Yeah, that was the main problem, I couldn't expect my mum to take me, wait for me, then bring me back home again, it was too much
(Tanya, non-compliant, response 28)

5.5.1.4.3 Content

Many participants were attracted to session 3. This seems to have been due to any (or all) of the three elements

(I) Bringing baby home

What about the actual content of the classes, I gave you the questionnaire at the clinic and I gave you the orange coloured leaflet; was there anything that struck you out of any of the brief outline that you thought - Oh, I'd like to know that ?

Well, obviously I wanted to know about bringing home the baby, and the postnatal one, that was very interesting

(Sarah, non-compliant, response 26)

(II) PND

That was the one about postnatal depression and bringing the baby home?

That's right. But he unfortunately had got called into work. That was the one I was really looking forward to.

(Emma, compliant, response 53)

(III) Involving their partner

I wanted the one at the night time [laughs]. I thought that would be really good, I thought that would be good for my partner as well.

(Emma, compliant, response 52)

5.5.1.4.4 Bringing along a friend/significant other/partner

Participants wanted to involve their partner so that he could hear first hand what they were being told. This avoided the possibility that vital information might be lost in the later re-communication to him of PND symptoms. Had their significant other come to the first 2 or 3 sessions then women might not have felt so daunted and shy. This might have promoted the establishment of better contacts within the group. Also, this might have solved the transport problem had their partner or mother accompanied them.

What about if your mum had been able to come along to the classes

Yeah, that would have been ideal as well, that way she could have been, not involved, but there as a support for me

Yes. And that would have been ideal, it would have helped ?

I think so, yeah

(Tanya, non-compliant, responses 25 - 26)

Would you have wanted to bring somebody, would that have made a difference?

Yeah, I think so, so you can actually talk about what you've heard, because you can never quite explain it the same way when you're telling someone about it can you?

(Rachel, non-compliant, response 57)

I'm a bit nervous on my own. I'm all right once I get there but, well I'm just shy, I'm all right once I get there, and I knew it would be interesting, all first time mums and that, but for the first time I would be like 'I want to go home' [laughs]

It was a bit daunting ?

Yeah.

(Tanya, non-compliant, responses 26 - 27)

Oh, I'd probably go along then, if my mates go along, if there's like a band of us, everyone go together. I'd be all right if I had a mate there.

Yeah, so if you came, you would have gone to the classes if you could have brought somebody along ?

Yeah.

They wouldn't necessarily have been your partner, so perhaps if one of your friends could come along?

Yeah, that would have been all right.

(Sadie, refuser, responses 88 - 90)

5.5.2 Maintaining engagement

Maintaining engagement and attendance at the intervention could be achieved by meeting the needs of the women (as perceived by themselves) and thereby improving their experience of the classes. These are the main themes that were identified as possible influencing factors. Note that the preponderance of participant responses quoted are from the compliant participants comments since they had experienced the intervention.

5.5.2.1 Providing reassurance

Reassurance was sought amongst the group and from the leaders. The participants all seem to have wanted to listen to the experiences of others. When they had gained sufficient confidence they could share their own good and bad experiences. This may explain why the groups took time to get started in terms of sharing experiences within the group. This may be the reason for the preference that women expressed for course leaders who have had children themselves. They are able to reveal their own experiences, thus boosting group members' morale and supporting those who are brave enough to open the discussion. See the course leaders section 5.5.2.5.1.

We was talking about things, how I said like, how you feel and everything, I mean I sat there and I thought I'm not saying anything and then towards the end you start coming out of yourself and you do say things, because the others are saying things, they're saying how they feel, you think well I'll say how I feel, you know, and it is a lot better.

(Samantha, non-compliant, response 23)

I suppose it was just, just being with all the girls. It was nice, all the information you gave us, just having other people around you who you could talk to about how you felt,

(Claire, compliant, response 35)

5.5.2.2 Normalising catalyst

The construct of 'being normal', with respect to their feelings during pregnancy to a first-time mum, is mainly based on society's perpetuation of, and media exposure to, a concept which is overly positive and on the whole unrealistic. This was supported by observations for the present

group. All the participants seemed genuinely surprised that other women did not feel entirely happy during their pregnancies. A great deal of reinforcement of more realistic expectations was needed to make participants feel that their experiences were normal. This had to be a very gradual process to avoid the fear level of the message reaching a point above that which is optimal, for changing the women's attitudes to, and expectations of motherhood, as found in attitude change research by (Leventhal *et al.*, 1965).

When exposed to the company of other pregnant women, the dissonance the women were beginning to become aware of, between how they actually felt and how they perceived they should feel (happy etc.) was reduced. They therefore no longer felt as much of an 'odd-one-out'. They then included themselves within the concept of 'normal pregnant women'. Thus they had normalised their feelings.

Because you could relate to what people were talking about and the fact that when we were talking, you could relate to others, and you realised you weren't the only one in the world [laughs]

(Emma, compliant, response 35)

I enjoyed what I did go to, you know, like talking to the other girls, how they were feeling, how you were feeling, you thought you were just one on your own but you weren't, you know, once you'd spoken to the others

Did you find that quite surprising then, that you

Yeah, 'cos like when you're pregnant and that, I don't know, like I thought it were just me that went through these things, like sometimes you get tired and you feel depressed a little bit, you know, like one day you're off, the next day like you might be OK and you think it's just you, but then when you talk to the other girls and they're going through exactly the same as well it's like really, I mean when I come out I used to feel like dead chirpy and happy 'cos, you know, it's not just me, it's like everybody, so yeah I did, I enjoyed that, (Samantha, non-compliant, responses 17 -18)

Did you feel able to sit there and talk about your situation?

Yeah, yes, the more I sort of got to know them. When I first went I did feel a bit strange, I did feel a bit on the outside. The more the other ladies spoke and said their problems, then you realised you know, you've got more things in common. We're all sort of feeling the same things and that, you know, you feel a lot better.

(Sarah, non-compliant, response 74)

5.5.2.3 Appreciation of sensitivity of subject

Few participants actually asked for information about how they were feeling. This does not necessarily mean that they wished not to know or that the medical profession/ midwives are unapproachable. Generally, the subject of mental health is very sensitive, particularly during pregnancy. They did not want to seek information from other professionals who may misinterpret

their desire for it. Many women seemed relieved that they had been informed about what they may, or may not, feel as they do not then risk the suspicion of 'being mad'.

Quite a lot of the time, GPs just don't mention the subject unless you ask. We also found that people don't usually want to go and ask for help.

You don't like to admit that maybe you might be feeling like that

But you ought to ?

Because, physical things yeah, admit to not feeling well but if you're feeling a bit

Odd,

A more sensitive issue...

You don't know if you're being paranoid or if you're wasting somebody's time, or if they think that you're slightly crackers, Do you know what I mean?

(Helen, compliant, responses 63 - 65)

5.5.2.4 Broadcasting the positive experience

The women found that what they had learnt was useful and could be applied to their everyday life. They mentioned that they had, amongst other things; gained confidence, developed the ability to generate different perspectives on problems, and felt that they were now able to be tactful, successful and remain in control when asking for and turning down support. The positive experiences that previous women have had could be used as part of the intervention. Examples of how the intervention can be applied within their own lives might be given, emphasising that other women have found it of value in the past.

So almost being allowed to ask them, that it was OK to ask, that its not a weakness

Yes

Other people do it, its fairly simple. And before?

Usually I'm not like that . I just struggle through myself, get on with it... My attitude was oh get on with it (said forcefully) even if it means breaking your back and that's how I used to work at home with my husband as well. I wouldn't ask him like for example gardening, if he was tired, I would just get the lawn mower out and just get on with it. But now its like if the lawn needs mowing (shakes head vigorously and makes an 'on your bike' gesture) [laughs] so yes I do ask for help now!

(Ameena, compliant, responses 46 - 51)

Did you find that you were using the information you'd been given in the classes?

Errm ..A bit yeah, especially the SODAS system (problem-solving), I felt I should be stopping and thinking you know, when I did try and cope I was sort of trying to stop and, you know, work my way through it

Do you still do it now or ?

Not so much, but I mean, I know, I suppose its made me think a bit more, how I feel in the situation rather than just jumping straight forward [laughs]

So you're sort of evaluating different things that you could do.

Yeah, what sort of options that I've got to deal with the problem

(Sarah, non-compliant, responses 62 - 64)

Yeah, that was fine, it was good, learning things, you know social support, turning it down, asking for help...

Yeah,

I think my problem is, my mum was very fussy when I was pregnant, she kept saying 'oh let me do this for you'. I didn't want her to. It's not because I didn't want to ask for help, I knew I could do it, and she made me feel that I couldn't do it.

Yeah,

Like she'd say 'oh do you want me call round and do some ironing?' or 'do you want me to work for you tonight?', and I'd say 'no I'm OK', and she couldn't understand why, why I'd end up snapping at her. I'd say to her, 'look, one day you know I am going to need your help, but at the moment I don't need it', and she couldn't understand. She'd say 'oh I'm not going to ask if you want my help anymore', but she did, you know. [laughs]

(Claire, compliant, responses 49 - 51)

5.5.2.5 Various practical themes

Again, four practical themes were identified from the data. These themes are relevant to maintaining the engagement of the participants once they have decided they would like to attend, and actually have attended, the intervention. These were: the course leaders, the balance between providing information and encouraging sharing within the sessions, the length of the sessions themselves, and the number of participant women considered to be a group for the intervention.

5.5.2.5.1 Course leaders

Both course leaders were mothers themselves. They felt that the course leaders could relate to what the group participants were saying, and they in turn respected the course leaders' advice. The atmosphere that they created and maintained enabled the women to feel secure.

Yeah, they were good. And I think it helped that they both had children as well. And they weren't frightened of saying yeah this does happen and that does happen, they didn't sort of try and sway you anyway. So if you asked them their opinion you knew they'd been there, so you know, and I think it helped. Probably somebody who hadn't had a baby might not have been, I don't know, so understanding of how we were all feeling at the time. I think it helped that they had both had children.

So, you think that actually because both the course leaders had children that that was a benefit?

Yeah, definitely

So, when you asked a question they could also give you a personal view?

And I think because they both had had totally different experiences of their children, you didn't get all this rosy from one, and from both you would see that it's not always rosy. So yeah, I thought that was good.

(Emma, compliant, responses 105 - 107)

Yeah, they was really nice they was, you know, and they didn't like, because I felt that I didn't speak and the other girls would speak she would never pressurise you and say 'well, you know, you're pregnant, what do you think of whatever?' and you just felt at ease and spoke when you wanted to speak, you know, so yeah, they were really good (Samantha, non-compliant, responses 27 - 29)

What about the course leaders? Did you find they were good ?

Very easy going.

Yeah?

It was good. You weren't judged , or anything like that, by what you were saying, it was just relaxed. But both, very, very pleasant, just relaxed

You felt you could say what you liked, you didn't feel restricted , inhibited anything ..

No, no, not at all, they were great, they weren't judging anyone.

(Helen, compliant, responses 71 - 75)

5.5.2.5.2 The balance between information and sharing

The participants did not want any more information/teaching incorporated in the sessions but they did want more time for personal revelation and sharing of experiences. In addition, more written information would have been useful so that they could re-read the handouts at a later date when they felt more ready or wanted to refresh their memory.

So do you think it would have been better if it was the same amount of information you were given but perhaps with more time to talk?

Yes, more time to talk. No the information was fine, the information was just right, but again in between we had so much to talk about

So if there was more time for you to talk with the other girls over the coffee break?

Yeah I mean we used to sit with the tutors as a group anyway. And then the tutors used to talk about their experiences which we found, well I found, valuable. There were a few times that we went over a bit (the coffee break) and they had to get back to the class

Yeah? You felt you had to drag yourself away?

And I used to think ooooh , I want to talk more

(Ameena, compliant, responses 142 - 144)

And then so you'd have more chance of getting different opinions. That's, there may be a chance of you actually finding someone who is feeling similar to you. Do you think that would be good ?

Yeah, that as well, but because I think because you do feel different things, to other people *Everyone's different*

Yeah, you see the different side of it, but it's just not for you. But at least you've seen, you understand, you've tried to understand

(Helen, compliant, responses 109 - 110)

I suppose it was just, just being with all the girls. It was nice, all the information you give us, just having other people around you who you could talk to about how you felt, (Claire, compliant, response 35)

Yeah. Do you think the information that you had about postnatal depression, do you think it was enough for you, too much, or perhaps just right?

I think personally yeah. I could keep it and read it later, particularly as I was thinking 'what am I going to do?', I was in a real state. It just made you sit back and look at the situation. Had to look at yourself from a different angle.

(Claire, compliant, response 67)

5.5.2.5.3 Length of sessions

Most women thought the sessions should have been longer so that they could have accommodated more sharing of experiences, which they all emphasised as being important for reassurance and normalising purposes.

Actually it could of been a bit longer. You sort of, everybody was a bit slow at getting started, and by the time everybody was in full flow,

You mean talking and coming out?

Yeah. It was like time to go home.

Oh right. Did that happen quite often throughout the sessions ?

Yeah,

Even right up to the end?

Yeah, more so at the end because there was only four of us, and we'd all got to know each other quite well you see..... So I mean we were like, we'd have the class and then we'd talk and add things onto it, and so it was getting further and further behind, so I thought maybe another half an hour.

(Emma, compliant, responses 98 - 103)

....more time at the sessions, say three hours. Two hours went by so quickly, especially with the break in between. Because it was a small group we would talk through most of it anyway , but yeah, a bit longer,

(Ameena, compliant, response 141)

5.5.2.5.4 Size of group

The women generally felt that they did not want it larger groups because group intimacy would have suffered, and the group would have been less comfortable, open, trusting, and relaxed. Nonetheless, it was also felt that groups should not be too small since this would have restricted their experience. The more mothers present, the more likely it is that they will meet somebody with similar feelings, outlook and experience. Such personal contacts act as a catalyst to encourage reassurance, and in turn leads to them feeling that their experiences' are "normal".

I think because we knew each other and knew quite a lot about each other we expanded more than if it was a bigger group, if it was a bigger group I don't think that would have happened.

(Emma, compliant, responses 102 - 104)

And what was it about the size of the group that you liked ?

I think if it's too many people you can't get to know them as well as if there only a few.

No, I think it was about right.

(Claire, compliant, responses 56 - 57)

And then when there were 4 of us there was more trust, you could be honest, it became like a little family

(Ameena, compliant, response 60)

So, what would have felt would be a comfortable size group?

Say probably about eight people

So you'd have more chance of getting different opinions? That is, there may be a chance of you actually finding someone who is feeling similar to you. Do you think that would be good ?

Yeah, that as well, but because I think because you do feel different things, to other people
(Helen, compliant, responses 106 - 110)

5.6 Conclusions of the qualitative analysis

As the themes identified by the analysis principally relate to two time points in the analysis, the screening stage and the intervention itself, improvements at these two time points need to be made to gain and maintain participant interest in the intervention. Following the suggestions made by the participants in the additional study, an intervention designed incorporating these actual experiences of the 'Preparing for Parenthood' classes, would be likely to have increased engagement.

6 Discussion

The principle objectives of the study were achieved. Factors that would improve engagement in a preventative intervention within this population were investigated. Unfortunately the intervention had very little influence on any of the factors investigated. The findings the study has produced are interesting in that they may inform the development of future interventions, hopefully enhancing compliance and improving their impact. Firstly the results of the quantitative study will be discussed in relation to the literature currently available. Secondly the results of the qualitative study will be discussed, again in relation to the currently available literature. The two studies findings are also discussed in relation to each other. This will be followed by an exploration of the strengths and weaknesses of the thesis. Finally suggestions for future research and the conclusions that can be drawn from the thesis are outlined.

The lack of compliance in the women randomised to receive the intervention, became an issue requiring further investigation from the beginning of the quantitative study. Although, prior to piloting the intervention, a market research survey was carried out, it was completed on just 14 women, only 6 of whom were first time mothers. This was not an adequate exploration of the population's feelings about attending a set of classes as an antenatal intervention. This was reflected in the poor attendance of the women. Hence engagement became a major issue and the trial provided an opportunity to study it.

Only 45% of women allocated to the intervention group met the criteria of having attended session 3 (PND) plus two other sessions (considered 'compliant'). This was a crucial factor in the development of the present study. Although throughout the pilot stage the researchers were aware of this particular problem there was insufficient time to resolve it satisfactorily prior to the RCT commencing. In order for an effective intervention to be developed it would seem necessary to establish a minimum engagement/compliance level and a strategy for its maintenance developed. Despite the discouraging results of the quantitative study, interesting observations came from the qualitative study which was undertaken after the RCT trial had been completed. The results of the quantitative study will be discussed first.

There were no significant differences between the three engagement sub-groups of compliant, non-compliant and refusers for the factors of locus of control, negative life events and poor social support in terms of their predicting attendance and thus engagement. Therefore it was not possible to support the hypothesis that engagement in the intervention will *increase* due to the presence of a combination of the antenatal trait characteristic that has previously been found to influence health

promoting behaviour and was explored in this study; which is: high internal locus of control, high powerful others locus of control, and low chance locus of control. It was also not possible to support the second hypothesis that engagement in the intervention will *decrease* due to the presence of poor psychosocial support in individuals currently experiencing low antenatal mood which has previously been found, in combination, to influence health-promoting behaviour. Nor was it possible to support the third hypothesis that engagement in the intervention may *decrease* due to the recent experience of negative life events that are contextually relevant i.e pregnancy related, which has also been found to influence health-promoting behaviour.

Nonetheless, two additional factors differed postnatally between the randomised (intervention and control) groups. Women in the intervention group were more likely than women in the control group to avoid their problems and have a high belief in powerful others. However, when the intervention group was broken down by *actual* attendance, these differences were no longer present. This implies that these findings were unlikely to be due to the intervention per se. As mentioned in the introduction, Labs & Wurtele (1986) concluded that the intention to attend antenatal classes was predictable with the internal sub-scale of their Fetal Health Locus of Control (FHLC) scale. *Actual* attendance of this intervention does not appear to have been predictable using any of the three FHLC sub-scale scores.

It would seem that in this particular population *actual* attendance of this intervention was not predictable from an individual having experienced a great number of recent negative life events (cf. Brown & Harris, 1978), or an individual having experienced few recent negative life events (cf. Solomon, 1989). The life event measure used was broken down into pregnancy specific life events, non-pregnancy specific life events and support threatening life events at the point of analysis. However, assessing the contextual relevance of the life events separately did not differentiate any more readily between individuals who were more likely or less likely to actually attend the intervention (cf. Bielawska-Batorowicz, 1990; who found a predictive difference in attendance with respect to contextually relevant lifestyle changes in pregnancy).

With regards to an individual's social support, *actual* attendance was not predictable using this variable. Whether the social support available and acceptable to an individual was perceived by them as excellent or poor, this did not make them any more or any less likely to attend the intervention. Therefore, health-promoting behaviour was not helped or hindered by a lack of either emotional or practical support (cf. Quine *et al.*, 1993; who found that well-supported women used

the health service more appropriately before and after birth, perhaps due to their enhanced sense of well-being).

The most (potentially) useful result was that a significant difference between the engagement sub-groups was identifiable on a factor that could be used to predict compliance within an antenatal psychosocial intervention. The women who declined to be randomised (refusers) had had significantly less contact with the NHS in the 12 months prior to the baseline assessment than either the compliant or the non-compliant participants. This implies that the refuser participants and acceptor participants are identifiably and predictably disparate from each other. As explained in the analysis plan (appendix 1) and the results section 5.3.5, the acceptor group (intervention and control groups combined) was equivalent to either of its' component groups as the participants of the intervention and control groups were found to be statistically interchangeable. Thus the intervention group was used split into its' compliant and non-compliant group components for the comparisons with the refuser participants. Therefore the factor identified from these analyses could be used to predict the self-selection of participants' initial engagement in the intervention, i.e. at the recruitment stage, as the refusers were predictably different from the acceptors. It did not, however, predict the differences within the acceptor group as no significant findings were produced between the participants who actually attended the intervention (compliant) and those who intended to attend but did not attend sufficient sessions of the intervention for it to have an impact on the prevention PND (non-compliant).

An age trend was noted between the sub-groups such that they could be ordered (using the group's mean age) from oldest to youngest as follows: compliant, refusers, and non-compliant. As such these findings, although only anecdotal due to the small size of the differences in mean age between the sub-groups, support the work of Quine *et al.* (1993). They found that older women experienced antenatal classes as more useful than younger women. It would logically follow that women who found the classes less useful would be unlikely to attend many of the classes. Thus a greater preponderance of younger women appear to fall into the non-compliant category of this study. The intervention study of Gorman & O'Hara (1998), which is detailed below, also noted a trend in the age of women completing the five sessions of their intervention, and those who were non-compliant. However, the differences in the average age of the sub-groups in the analysis in the present study and those of Gorman (1998) were small. No significant differences were found between the compliant and non-compliant groups for any of the factors investigated in the present study.

As an aside, the results from the RCT trial concluded, somewhat unexpectedly, that an individual's level of depression is no more or less likely to be high postnatally if they were in the intervention group than if they were in the control group. Furthermore, if the woman was a compliant member of the intervention group (attended session 3, about postnatal depression, plus at least two other sessions), as oppose to being allocated to the control group, she would be more likely to have a heightened level of depression 3 months after the birth of her first child. Therefore the antenatal psychosocial intervention designed to prevent postnatal depression did not achieve it's primary aim as PND was more prevalent in the compliant section of the intervention group. This finding has little bearing on the results of the studies in this thesis as the samples level of depression was stratified for at the randomisation stage and consequently was not found to be a significant predictor of actual engagement to this intervention. However, this finding is mentioned as a point of information for curious others who may wish to read the RCT trial results in Brugha, Wheatley *et al.* (1999) and to place the quantitative study in context with other recent intervention studies to prevent PND such as the one described below.

A study is currently being carried out in the Netherlands by Wijnen *et al.* (1998) to investigate the impact on postnatal depression of a counselling intervention consisting of 10 weekly home visits by a trained therapist commencing between 4 and 14 weeks postnatally. Preliminary results have shown that women who were identified as at high risk antenatally and chose to have the intervention (n=90) were more likely to be primagravidas than multigravidas and to have had a major depression antenatally, than the women identified as at high risk but who chose not to receive the intervention (n=112). Randomisation was not used to allocate participants to the intervention or control conditions. Intriguingly, they also found no significant difference with respect to the impact of their intervention upon the prevention of postnatal depression.

The self-selection component of engagement to the Netherland research groups intervention has encouraged them to undertake an exploratory study of the characteristics of the women who wish to receive the intervention and those who did not wish to receive the intervention (Pop, 1998). The study is currently in the developmental stage but has arisen due to the research team's desire to identify if the two groups of women are perhaps mutually exclusive of each other. If that emerges to be the case, this would add more weight to the consideration of developing interventions tailored to individuals that fall into opposing health-promoting behaviour categories, in particular, information-seekers (monitors) or information-avoiders (blunters), (Miller & Mangan, 1983; Steptoe & O'Sullivan, 1986).

From the analysis of the qualitative data seven themes were identified as being reportedly influential in *initiating* engagement to the 'Preparing for Parenthood' intervention. These were: the individual's assessment of their need for information about PND; the non-perpetuation of the PND taboo; enhancing the decision-making process; and practical issues of the intervention's structure and design, such as having the classes at a more convenient time, in a more convenient location, emphasising the contents of the intervention that the women wanted to know about in the participant leaflet, and being able to bring along a significant other to the initial meeting and the PND session.

Eight themes were identified as being potentially influential in *maintaining* engagement with the intervention. These were: the group providing mutual reassurance; the group acting as a catalyst to the normalising process; appreciation of the sensitivity of the subject of PND by the course leaders; broadcasting the positive experiences of previous participants to those just beginning the intervention; and the practical issues of the intervention's structure and design, such as, having course leaders who are parents themselves, altering the balance of time spent on information-providing and sharing so that the emphasis is more on sharing, increasing the length of the sessions to accommodate this, and halving the size of a defined 'group' from sixteen to eight women.

To place the findings of the qualitative study in context with regard to the psychology of health-promotion, two studies recently completed will be outlined. Neither study has (so far) addressed the issue of engagement to their health-promoting intervention, preferring to concentrate on the efficacy of their design with respect to a reduction in PND. The first is a study carried out in Scotland to explore the transition to parenthood in couples expecting their first baby from the general population (who were not identified as at risk of PND) which also did not find any significant difference in maternal postnatal depression (Ross, 1998). The trial consisted of a randomised design exploring the method of presentation of an intervention (n=171 couples). The conditions were: (1) directed anticipatory guidance + workbook; (2) non-directed anticipatory guidance; (3) workbook only; and (4) control. Where guidance was part of the intervention, these were run as two additional classes added on to the standard 5 antenatal classes. The attrition rate experienced in the study was 28% in total and was greatest in those conditions that involved the workbook about the transition to parenthood. A procedure was followed to see whether the participants had actually read the workbook. They were sent a brief questionnaire to complete and from this it was inferred that all those participants allocated to that condition had indeed read the

workbook. Therefore, whilst the method of presentation of the intervention did not appear to have an impact on the development of PND, it did have an impact on the maintenance, or loss of, engagement of the participants to the intervention. The issue of the need for balance in the content, and the presentation of the content, of the Preparing for Parenthood intervention was suggested by the participants as a central theme in the qualitative study findings of this thesis with regard to maintaining engagement.

Another study of the prevention of postnatal depression using an intervention has been run in the USA incorporating interpersonal psychotherapy in the intervention (Gorman & O'Hara, 1998). With regards to efficacy, this study was found to have a significant impact on PND one month after birth but not six months postnatally. The multi-and prima-gravida participants were identified as at high risk at approximately week 32 of pregnancy and were then randomised to either the treatment (n=24) or control condition (n=21). The treatment condition participants were seen once a week for two weeks antenatally, and then once a week for three weeks from the second postnatal week (five individual sessions in total). The control participants continued with standard maternity care. The counselling sessions were intended to take place in the psychology training clinic. However, 45% of sessions were held in the women's home antenatally and postnatally, 30% were held in both locations at some point in the study, and 25% were held purely in the training clinic as intended. This may go some way to explain the low attrition rate of the study, approximately 15%. Reasons that were given for non-compliance included time pressures and travel problems. Both of these reasons may have been relieved by the therapist going to the participants home thus increasing engagement. Interestingly the participants in the qualitative study of this thesis, whilst keen to have the intervention held in a location closer to their home, did not mention a preference for the intervention to be carried out actually in their own home. The most obvious explanation for the absence of this suggestion is that the Preparing for Parenthood intervention was a group design and thus by its nature and in its current format it is not suitable for translation into a participants home.

The findings from the qualitative study are those which are most heavily drawn on when considering reassembling the intervention and the implications for future research and practitioners which are discussed shortly. These issues are centralised around the idea of developing an effective *and* attractive psychosocial intervention to prevent postnatal depression.

6.1 Consideration of the Strengths and Weaknesses of the Thesis

The intervention employed a clearly documented training and implementation manual, the application of which was monitored consistently throughout the study both from the point of view of the course leaders conveying the required information and the participants perception of the information they were being presented with. Thus conclusions can be confidently drawn in relation to all of the eight groups for the core study that were run between spring 1996 and summer 1997, and the additional group that was run for the qualitative study in late autumn and early winter 1997. Therefore, the results of the quantitative study and those of the qualitative study have high internal validity.

However, this relates less favourably to one area of the quantitative study that can only be described as procedurally weak with regards to the issue of engagement. This is the non-investigation of the participant women's evaluation of the attempts made to encourage and sustain their engagement to the intervention in the quantitative study. This was mentioned earlier in the thesis in the section exploring the idea that an opportunity had been lost. Due to the balance that had to continue to be nurtured between (1) maintaining consistency throughout all the eight groups of that study and (2) the possible value of the data produced by including a measure to explore engagement once the trial had begun, it was decided amongst the research team that the internal validity of the quantitative study and the RCT trial as a whole should take precedence. The inclusion of a measure of engagement, or perhaps more appropriately, a measure exploring the reasons for non-engagement would have provided a data set that would have enabled a more thorough exploration of the issue than is possible with the present measures of the study. Such data would have provided additional findings at more points of the study, for example those participants who declined the baseline assessment, and may have supported or questioned the currently available findings and thus enhance the suggestions for future research.

Central to such an exploratory measure in the context of the present study would have been a question asking if the women really knew what they were saying yes to at the different points of contact in the study. It would be interesting to contrast what they expected with what they perceived they actually received. In the qualitative study it became apparent that the majority of women were glad to take part in the study by completing a questionnaire but admitted to feelings of suspicion when they were invited to take part in the intervention classes. Unfortunately, data was not collected to investigate the reasons for this change of attitude in either the quantitative or qualitative studies of the thesis, and nor were any reasons spontaneously produced in the

qualitative study. The inclusion of a set of carefully selected questions to measure this would have provided just such information.

Blindness was successfully maintained for the RA carrying out the outcome assessments for all of the participants, regardless of whether they had actually attended the intervention or not. This suggests that future studies wishing to explore the engagement of individuals to a health-promoting engagement can be facilitated under controlled and scientific conditions using similar methods to those employed in this thesis. In the quantitative study, the randomisation procedure enabled concealment of allocation to be confidently assumed. As it was computerised it was uniformly carried out for each and every woman wishing to have the opportunity of being randomised. The three month postnatal outcome assessment was completed by a researcher blind to the participant's allocation to either the intervention or control groups. Therefore any expectations the researcher may have had of women who had attended the intervention, and those who had not attended, would not confound the assessment.

However, blindness among participants was not possible in the quantitative study as, after randomisation, they knew whether they were in the intervention group and would be invited to the Preparing for Parenthood classes, or that they were in the control group and would continue with standard care until they were seen again at 3 months postnatal. This may influence the outcome of a study in a variety of ways, in particular, the reliability and validity of outcome assessments.

The fact that a participant has no choice over determining whether they receive the intervention or not may also be influential although this is a difficult issue to resolve under currently available methodologies (Brewin & Bradley, 1989). Those who are randomised to the intervention know that they are getting the treatment they want, and those who are randomised to the control group know that they are not getting the treatment they want. This is bound to make some difference to the participant's experiences at this time in their life and as such may have an unknown impact upon the health-promoting variables under investigation in this study which are experientially based. These kinds of issue have been discussed by a number of investigators, for example, the preference trial idea of Brewin & Bradley (1989). More recently the issue of patient preference has been reviewed by the Health Technology Assessment (HTA) programme. The authors suggest the use of a simple additive model to take the influencing factor of preference into account when considering the results of RCT trials and their comparison with non-randomised studies (Britton, McKee, *et al.* 1998). The review suggests that preference may have the greatest impact where

blindness is difficult to achieve, therefore, preference should have had only a limited impact on the quantitative study.

In the qualitative study, blindness was not a necessary requirement for the postnatal interview. Indeed, the interview transcriptions were analysed as a complete sample without being divided into the three discrete engagement sub-groups to maximise the efficiency of the technique of grounded theory analysis.

6.2 Reassembling the Intervention

These are drawn from the findings of the quantitative study and the qualitative study.

6.2.1 Participant recommendations

Many women from the quantitative study completed the ‘any further comments’ section on their postnatal course feedback forms. The suggestions varied but the following five points summarise the samples feeling’s as a whole. Firstly, that they would have liked more information about postnatal depression and that it was OK to feel “apprehensive and frightened” during pregnancy and early motherhood, this provided them with a realistic definition of what it is ‘normal’ to feel at this time in their lives. Secondly, that it was great to be able to share and discuss experiences and expectations openly with other pregnant women. Thirdly, there was too much repetition in general and in particular about problem solving. Fourthly, a more relaxed, informal, less didactic approach to conveying the information would have been an improvement. Finally, more open, whole group, discussions would have been useful. Clearly an extended developmental phase could have efficiently identified and addressed such issues prior to formal trial evaluation. These findings are similar in nature to those of the qualitative study’s results summarised above.

It should be borne in mind that much like intended behaviour being loosely related to actual behaviour, what people say about what they think they like often does not reflect what they actually like. Therefore, these participant-sourced recommendations should be used as guidelines, not instructions, to aid construction of the ‘perfect’ intervention. They do, nonetheless, represent a very solid base to build upon.

The intervention was antenatal and as such was not carried out in the defined period of risk i.e. the early postpartum. Indeed, some women commented on their 3 month course feedback forms, that this was detrimental to their experience of the intervention. In answer to the question ‘How do you think this course has helped you?’ one woman replied “It was helpful at the time, but I was

only half way through my pregnancy so it [the information] got put at the back of my mind". Another woman said "Now, not a lot, but at the time a great deal". This problem may be a particular issue for preventive interventions because of the lack of a perceived need by the participant's at the time that they are receiving the intervention. If they are currently well, information about being unwell and what to do if they become unwell, is not particularly salient. As such it is more likely to be dismissed as irrelevant to their life at that point in time. Therefore, the intervention may experience better engagement and be more effective if it was held in the postnatal period of defined risk.

6.2.2 Course Leader recommendations

A further important practical issue was the challenge of trying to address appropriately multicultural issues, both in the study design and in the development and running of the groups themselves. The difficulties of cross-cultural work in the field of mental health in general is widely recognised as being problematic (Littlewood, 1990). In particular, the differences in the individual's interpretation and observation of culturally based rituals around the time of childbirth compounds the complexity of studies carried out at this time with a multi-cultural sample. Although many of the 82 Asian women in the study (28% of the total sample) were the second generation of their families to have lived in Britain, they were often the first generation to have been born and reared in Britain. It was clear from the comments of the course leaders that the expectations of their families sometimes differed in important ways from those of European women. It was thought that this may have influenced engagement. However, engagement did not appear to significantly differ within Asian women or between European and Asian women in the compliant, non-compliant and refuser sub-groups of the study. Unfortunately, the impact of the intervention and how it differed from the European women's experience of the classes could only be speculated about at this time as it was not investigated in this study. Nonetheless, work exploring this unique group of Asian women who, as it were, stand with a foot firmly planted in each culture, is currently being undertaken to investigate various cross-cultural conceptual issues surrounding PND at the Leicester General Hospital, stimulated by the findings of this thesis (Crossley, 1998).

6.3 *Implications of this Thesis*

These will be divided into two areas, with respect to practitioners and in relation to future research.

6.3.1 For practitioners

The issue of needing to clarify and being aware of the distinction between ‘effective’ health promotion and ‘pleasant’ health promotion was raised by this study. Interventions that are developed and applied in the future must try to strike a balance between these two factors, not an easy task (Wheatley & Brugha, 1999). The majority of women who attended the intervention stated that they had enjoyed it, viewed it as a worthwhile experience, would recommend it to a friend, and would like to go to something similar if and when they had their second child. Nonetheless, the intervention did not improve their emotional well-being significantly (Brugha, Wheatley *et al.*, 1998).

It is hoped that practitioners and researchers may, as a result of encountering this thesis, be prompted into methodically assessing their own success in promoting appropriate health service usage. A simple first step would be to investigate their ability to engage their clients and/or participants.

6.3.1 For future research

Leading on from this study, it can be suggested that potential engagement in an antenatal intervention such as this could be assessed at the screening stage by including items in the questionnaire to assess recent service contact. In much the same way that current depression is predictive of future depression in this target population, current service contact is predictive of future service contact. However, prior to any definitive conclusions being made, the measure used to assess service contact in this study needs to be deconstructed. This would establish whether the refuser participants did not have as much contact with the NHS because they did not want to seek help when they were ill, i.e. they are blunterners. Alternatively, it may be that they are simply not ill as often as the compliant and non-compliant sub-groups of this study and therefore did not need to contact the NHS for health care. The service contact measure included a component to assess satisfaction with the care they received (if they had any contact with any of the services) and it is possible that this might have been the critical component in predicting their engagement in future health-promoting behaviours. Further assessment of this factor using a measure developed to provide greater detail is therefore necessary.

Another factor that was noted to exhibit a (non significant) trend in its ability to predict engagement in health-promoting behaviours amongst the target population was age. Younger women tended to be more likely to not engage in the intervention group. This finding was broadly consistent with evidence from previous studies. It is also a factor that could be included in a

screening questionnaire to be used to indicate future engagement. Asking someone their age does not induce an unreasonable level of fear in a person and as such is comparatively simple information to elicit. Especially compared with, for example, when asking about previous psychiatric history to gather information to act as a predictor of PND. Future research could also attempt to establish whether it is age per se that predicts engagement, or another age-related factor. For example, relationship stability, educational level, or perhaps their perception of the amount of life-change and situational disruption a baby brings. All these factors (and many more) could be associated with age and its' impact on engagement. Or independently one of them could be the factor at the root of reliable prediction of engagement in the target population.

In conclusion, the only significant result of the quantitative study in relation to engagement was that the women who declined to be randomised (refusers) had significantly less contact with the NHS in the 12 months prior to the baseline assessment than either the compliant or the non-compliant participants. However, no significant differences were found between the compliant and non-compliant participants. In the qualitative study, analysis using the grounded theory technique identified two main categories of themes, clustering at either the screening stage or at the intervention stage itself. Seven themes were identified as influential in *initiating* engagement with the intervention; and eight themes were identified as being influential in *maintaining* engagement with the intervention. Additional research in the wider field needs to address the possibility that the method and content of contact with individuals from different engagement sub-groups (once identified at screening) ought to be tailored to maximise their initial engagement. This can only be done when the factors specific to each group have been identified. From this a model to target attitudes to help-seeking with regards to health-related issues could be developed and applied. Likewise, the antenatal intervention developed in this study ought to be modified to sustain engagement with the participants. This study has provided several suggestions for both issues to successfully gain and maintain engagement in an antenatal intervention.

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Appendix 1: Quantitative Analysis Plan

Planned analysis - initially discussed on 27th January 1998

1. Decide on a cut-point to apply to the primary outcome variable of engagement to the intervention. This will be a binary outcome, the categories of which will be labeled 'compliant' or 'non-compliant' and will relate to the participants attendance of the intervention. The decision will be guided, largely theoretically, by the implementation of previous research into the prediction of actual health-promoting behaviour (compliant) and the prediction of intended health-promoting behaviour (non-compliant).
2. Decide on cut-points for the three health-promoting variables under investigation as binary outcomes at 3 months. Again, these will be theoretically guided. The outcomes will be binary to ease their identification as being either 'present' or 'absent' when included in a self-completion screening questionnaire format for the prediction of engagement to an intervention.
3. Tabulate the baseline and demographic data (all antenatal) for the engagement sub-groups to ascertain that they are comparable to each other and representative of the target population as a whole. The engagement sub-groups are: intervention (splitting to become compliant and non-compliant), control and refusers. Of particular interest are the compliant, non-compliant and refusers.

Review the results so far, before continuing:

PRIMARY ANALYSIS:

4. Logistic regression using SAS PROC LOGISTIC of the antenatal variables measured, with particular emphasis on the results of the analysis of the three health-promoting variables, comparing compliant and non-compliant groups. This should help to clarify the differences seen when the engagement sub-group who self-selected themselves out of the possibility of receiving the intervention (the refusers) are analysed in comparison with those who self-selected to have the opportunity to receive the intervention (the acceptors).
If it is established that the intervention and control groups are demographically comparable, which it is expected that they will be as stratification at randomisation should have controlled for any differences between the intervention and control groups and therefore within the acceptor group, then only one of the two randomised groups need be included in the comparison. The intervention group data will be used, as oppose to the control group data, as the engagement of the intervention group is of central importance to this thesis. Thus each of the intervention's engagement sub-groups are to be compared in turn with the refuser sub-group. This will provide more detailed data from fewer analyses to identify antenatal predictors of engagement.
If there is no internal reliability and validity within the acceptor group, i.e. between the intervention and control women, then a direct comparison will be made of acceptors vs. refusers. Then the acceptor group will be broken down into the intervention's engagement sub-groups and compared with the refuser sub-group in turn.

5. Logistic regression using SAS PROC LOGISTIC of the antenatal variables measured, with particular emphasis on the results of the analysis of the three health-promoting variables, comparing compliant and refuser groups.
6. Logistic regression using SAS PROC LOGISTIC of the antenatal variables measured, with particular emphasis on the results of the analysis of the three health-promoting variables, comparing refuser and non-compliant groups.

Review the results so far, before continuing:

SECONDARY ANALYSIS:

7. Logistic regression of antenatal locus of control scores of significant items breaking the sample down into the three engagement sub-groups to identify simple predictors of engagement that could be used in a screening measure.
8. Logistic regression of antenatal social support scores of significant items breaking the sample down into the three engagement sub-groups.
9. Logistic regression of antenatal life event scores of significant items breaking the sample down into the three engagement sub-groups

Review the results so far, before continuing:

TERTIARY ANALYSIS:

10. Logistic regression using SAS PROC LOGISTIC of the postnatal variables measured, with particular emphasis on the results of the analysis of the three health-promoting variables, comparing the intervention and control groups. This should provide a touchstone to compare the findings of the following analyses when the intervention group is split according to engagement (compliance) to monitor the impact the intervention may have had on the three health -promoting variables, as in the next step.
11. Logistic regression using SAS PROC LOGISTIC of the postnatal variables measured, with particular emphasis on the results of the analysis of the three health-promoting variables, comparing the compliant and non-compliant groups.

Appendix 2: Interviewers Guidesheet

Qualitative interview Questions

This is a chat to enable us to evaluate and improve our research methods. Some girls decided to have the opportunity to do the 'Preparing for Parenthood' classes, some girls decided not to have the opportunity to do the 'Preparing for Parenthood' classes, and some girls didn't manage to come to the classes in the end. We are approaching all the women who showed an initial interest in our classes to ask them to help us. Today is similar to what we have asked you to help us with in the past, however, I will not be asking you to fill in any questionnaires. I'll ask some questions and if you could tell me fully, and completely honestly, what you think. There are no right or wrong answers. Everything you say is completely confidential and is of great value to us.

Introductory questions:

How many months old is your baby at the moment?

What is your baby's name?

What do you think you enjoyed about being pregnant?

What didn't you like about being pregnant?

Core questions:

1. When you received the Pregnancy & You questionnaire, why did you think you were being asked to help us?
2. Did you talk to anyone about deciding whether or not to attend the classes?
3. What did you take into consideration when deciding if the classes were for you?
e.g. content, location, timing, travel
4. What had you heard about postnatal depression before I spoke to you in the antenatal clinic?
5. The thought of postnatal depression - that you might be that one woman in ten - how did that make you feel?
6. Looking back, do you think you (would have) enjoyed the classes?
7. Did you go to the classes run by the midwives?
Yes - What did you think of the classes?
No - Why didn't you go to the classes?
8. If you could turn the clock back to when I saw you when you were pregnant, would your decision to attend or not attend the 'Preparing for Parenthood' classes be different now?
9. If there was one thing - anything - that you could change to improve the classes what would it be?

Appendix 3: 'Preparing for Parenthood': An antenatal psychosocial intervention for the prevention of postnatal depression

Preparing for Parenthood

Practical and emotional aspects

A 6 weeks course for women expecting their first baby

The aim of this course is to help make becoming a parent, easier and more enjoyable. It will provide the chance to talk about the concerns that are bound to go with this "new job", and help you find ways of reducing the strains and stresses, both now and in the future. The focus is on the practical and emotional aspects of parenthood, and taking care of yourself in the broadest sense. Currently, about 1 in 10 women experience post natal depression in the weeks and months following the birth. This course is designed to reduce the chances of this occurring.

We have found that it is helpful to have a combination of structured input, "free discussion" and exercises to do at home. The topics and timetable of meetings is outlined on the next page. You will be encouraged to relate topics to your own life situation, and to raise issues that particularly interest you. However, in order to cover a wide range of helpful topics, we will keep more or less to the timetable.

Pre-course meeting. The course leaders will meet with you to discuss the course, and to begin to get to know you. They can answer your questions and together you can discuss how the course could help you. Your partner, or someone close to you, is welcome to come to this meeting, which will usually be in the ante-natal clinic.

Handouts will be given out at the end of each session, summarising the main points and providing further information. You will also have the chance to build up a personal file for you to keep and look at, long after the course has finished

Course Content

Session 1: *Becoming a mother: what does it mean for me?*

Session 2: *Ways of coping.*

Session 3: *Life with a new baby
Recognising and preventing post natal
depression
Videos and discussion.*

Please bring your partner/friend/mother to this evening meeting.

Session 4: *Social Support*

Session 5: *Putting changes into action*

Session 6: *Coming to the end, and facing a new
beginning*

Reunion: *How are we? Where to from now?*

Initial Individual Meeting.

Background information.

Before your initial meeting , these women will have already :

1. filled in a screening questionnaire at the antenatal clinic. This asked questions about the circumstances of the pregnancy, about their feelings about the pregnancy and the “stresses and strains” they were currently experiencing (GHQ items relating to depression). This will probably have happened quite early on in their pregnancy.

2. had a lengthy interview with the research assistant at their home. This will have involved a detailed analysis of their social support network as well as further questionnaires.

The project will have been presented as a study of the “strains and stresses” associated with pregnancy and parenthood, and more specifically, that it’s about reducing the possibility of post natal depression . The researcher will have mentioned that about 1 in 10 women experience some degree of post natal depression, and that whilst we cannot predict who will/won’t experience PND, we do have knowledge about what can prevent it developing, and how to reduce the degree of depression. It is explained that the course is designed to target those topics that have been shown to be helpful in preventing PND. You may want to repeat or expand on this in the initial meeting. Appropriate consent will have been obtained. They will have been told that the offer of a place on the course is determined by chance (random allocation) following the research interview. After the research interview, they will have been informed about having a place on the course, and sent a letter with the *information leaflet* about the course and a date to meet with you at the Maternity Unit. They will have been invited to bring their partner (if they have one) to this first meeting.

Initial Meeting.

Goals:

1. for the participants to understand what the course is about and its “working model”. (*Orientation*)
2. for the course leaders to check out that the participant is appropriate for the course, and if not, to discuss alternative help. (*Assessment*)
3. to promote *engagement* and *interest* in the course (both the woman and her partner).

Materials:

Participants leaflet about the course.

Writing paper

Checklist record.

E.P.D.S.

Content of meeting:

1 *Introduction:

(Within the first 10 minutes or so include the following):

***Rationale.**

Provide rationale for today's meeting e.g. "an opportunity for you to find out more about the course, to see what it has to offer you, and to think about whether you want to come. A chance to talk about any concerns (worries or practical problems) that you might have about coming. It's also a chance for us to begin to get to know each other."

If the partner is present, explain that as a matter of course we always have 5 minutes at the end of the meeting with each person to talk separately with the course leaders to check out anything that's not clear. This is your chance to check out anything they felt inhibited about saying in front of each other.

*** Research aspect.**

Acknowledge all the research forms and interview that they have already been through e.g. "I realise that you have already filled in a number of forms and had a long meeting with the researcher, and now here you are again meeting with us. We appreciate the time and effort you've already put into this; we hope the course will give you (both) something useful". Explain that the research side is separate from the course in the sense that you don't know what they said to Sandra. Check out what they understand about the research element, and correct misunderstandings. Mention the follow-up interviews.

***Initial reactions.**

Check out initial reactions to course so far e.g. "how did you feel when you learnt you had been invited to come on the course?" (If she asks why she has been chosen, you can say that from what she said on the very first questionnaires that she filled in at her first ante-natal visit, it sounded as if she was currently experiencing some strains and stresses, and that we feel that this course would most benefit people like her, who are experiencing some stress right now. If appropriate, do point out that just because they are experiencing some stress now, does not mean that they will develop PND. Explain that we can't predict accurately who will develop PND, but that we do have information about ways of preventing it- and that's what the course includes.) "We sent you a leaflet about the course. Have you received it? Have you had a chance to look at it yet? What did you make of it?"

(The reason for including these points early on is so that the participants have a clear understanding of the reason for this meeting and a clear "bridge" is made between the research meeting and now. It's also very important that we acknowledge how she (and the partner) feels; she will have been meeting a whole range of health professionals recently, and we want to give the message that we are thinking about her experience and are responsive to her thoughts. Whilst we very much hope that she will decide to attend the course, our aim is that she will come to that decision for herself, having voiced her

doubts/anxieties, rather than as a result of being “persuaded “ or politely agreeing ,only to drop out later.).

How you decide to cover the items mentioned on the checklist, is largely up to your discretion and judgement. The atmosphere of the meeting is intended to be friendly, open, inviting self disclosure as far as the participant(s) want to, leaving her very much in the driving seat; it’s a “meeting of equals”, albeit you have different roles. Include the partner ,invite their perspective and concerns with a view to engaging their support, but the main focus is on the woman. The idea is to give her a flavour of the tone of the course i.e. it’s woman centred, open and honest, respectful of individuals’ ideas, hopes, experiences, empowering, collaborative, and responsive. The course is NOT about being told what to do /how to be/what’s right. It’s NOT about pretending everything’s alright when it’s not, nor having to agree with others’ points of view. It is about taking time to think about yourself, your situation and explore ways that may be helpful to you in reducing the strains and stresses of being a parent. And it is structured, so that whilst women will be encouraged to be very involved in the meetings, there will also be a clear framework to each meeting. This enables the group to cover a lot of material and prevents it becoming just a “chat”.

2* Orientation:

***Course content and rationale:**

Expand on the course content and its rationale (general rationale : “To help reduce the strains and stresses that women very commonly experience during the early months of being a mother, and to reduce the chances of PND”. See above section also.) It may be appropriate to explain the rationale for individual elements/topics if the participant looks confused/sceptical about certain sessions. Be sure to mention the topic of social support and its importance at some point. Make it clear that this is in addition to the usual Parentcraft classes, but that it has the same status i.e. employers should provide time off work. Explain they can get fares reimbursed by you.

***Course structure:**

Explain the structure of the course i.e. 6 weekly meetings, lasting 2 hours fromto, with a reunion about 4-6 weeks after the babies have been born. We strongly encourage people to come to all the meetings , as far as they are able, both for their own benefit (since topics will build on what’s been discussed the weeks before,) and also for the sense of cohesion and trust within the group. Draw participants attention to the fact that the third meeting is open to her significant other (partner, mum or friend), whoever she feels will be the closest to her during the pregnancy and in bringing up the baby.

***Course format:**

Explain the format of each meeting i.e. a mixture of information and suggested topics for discussion, some “exercises” to illustrate points, videos, sharing ideas and experiences, helping each other “problem solve”, time to raise own concerns. Explain the “working model” , i.e. “ the idea is that lots of issues will be raised in the meetings and we

will offer some ways of approaching things, but that's only 2 hours a week: there's a lot of time between the groups that we can also make use of, hence there will be written information given at the end of each meeting, and "self help exercises" i.e. things that you can try out at home and discover for yourself what's helpful. One of the most important aspects is learning to recognise when something that's been talked about in the group is happening in your lives i.e. developing self awareness, self monitoring, capturing those "ah ha" moments. After all it doesn't really help in the long run to be aware of things as we sit together in the hospital, if you can't relate it to your life. Also going over things later helps you remember it and discover what's really relevant and meaningful to you. So we will be suggesting that you think about or try something in between each session." Explain that they are invited to be as actively involved as they feel able; "it's the sort of course where each person has things to contribute, and the more you put into it, probably the more you will get out of it. That doesn't mean that you have to talk, but if you can think about how this fits into your life etc that will probably make the course more helpful." But equally, it's up to each person to decide how much they want to be involved; we're all different and we know what suits us best at any particular time.

***Group composition:**

Explain the group composition i.e. about 8 women, all of whom are expecting their first child. All recruited in the same way, and they will be together as a group for the course, as will the 2 group leaders: no more strange faces joining halfway through, except "x" our male colleague who will be joining the 3rd meeting.

3*Assessment:

- It is very unlikely that someone will not be suitable for the course. If you have any doubts about their ability to read/write/understand what you are saying check this out sensitively e.g. "can I just check with you whether I explained that clearly? Can you tell me what I was just talking about. On the leaflet, which meeting interested you most?"
- If they seem unable to concentrate, listen, seem very seriously depressed/anxious/suspicious talk about this with them, and discuss whether they feel able to attend the course.

If you think that she is definitely unsuitable, then take a break and discuss this with your co-leader, and then with her, sharing your reservations about her suitability for this particular course at this particular time. Try and encourage her to think about whether any other form of help might be useful, and offer to help arrange this if she would like it. If you are unsure about someone's suitability, defer offering her a place on the course, and say you're not quite sure whether this is the right thing for her, but you'd like to talk with another colleague about it, and will get back to her soon.

(Record in detail reasons for unsuitability.)

4* Promote engagement:

(this is a very important aspect of this meeting: the following are suggestions about how you might promote engagement, but use your judgement and creativity).

- help the participant identify meetings that particularly interest her, and try to help her work out what she might get out of the course. If she doesn't seem particularly interested, it might be worth discussing how hard it is to know now what might be useful later. (Indeed that was a clear finding when we "market researched" this course and asked pregnant women whether they would like to come on a course like this: those who had already had children were very positive about the course, and were very clear that it was just what they could have done with. But women pregnant with their first child, whilst thinking that it sounded interesting, were not as sure that it would be useful.) Also help the partner, if present to see what he/she might get from the 3rd meeting.
- If the participant is unsure about attending, help her to "problem solve" i.e. stop and recognise that there's a problem; clarify the problem; brainstorm possible options and the consequence of following these options; decide which option to follow. Clarifying the "problem" may be a very useful area to focus on, and even if the participant seems keen to attend, encourage her to think about any difficulties she might have in attending e.g. time off from work, travel, anxieties about the group, bad experiences in other "courses"/school, bad experiences with other health professionals/the hospital. Help her to "problem solve" these. Engage partner's help if appropriate.
- Encourage the participant (and partner) to ask you any questions about the course, however "silly" she thinks they are. If you have any hunches about what she might be thinking, talk about them.

The basic message is, "Let's be as open and frank as we can so that you are in the best position possible to do what you think is best for you". That includes you the group leader being free to sensitively challenge erroneous assumptions, and to offer alternative ways of seeing things e.g. "you seem to be saying to yourself that since you felt awful in an evening class 2 years ago you're going to feel the same at this course. Well you might be right, but I'm wondering what makes you so sure that you would feel "awful" at this course. Maybe not all courses are the same, maybe you are different now, maybe a whole lot of things I wonder if it would be helpful to think a bit more about this together now, because otherwise I can see the possibility that you might be held back by this unpleasant experience, and deprive yourself of new and interesting opportunities." However you will have to use your judgement about how much it is appropriate to challenge; this is not an agreed therapeutic relationship and it is essential we do not leave participants feeling attacked or undermined. If after some

discussion the participant is saying she does not want to come (even if she is not saying it clearly) we need to respect that and leave her feeling that that's fine, but that if she does change her mind in the near future or want to talk about it some more, she is welcome to contact you.

5 Separate time:(if partner present)

Encourage about 5 minutes for them to talk separately with you. Explore anything that may have been hard to say in front of the partner.

6*Summary and practicalities.

Summarise what you understand the participant to be saying about her attitude to coming to the course, and anything you have offered to help with e.g. providing an appointment card for her employer.

Provide the project phone number.

Offer travel expenses: if they would like to claim travel expenses for their journey to and from the course, they should bring receipts to you and you can reimburse them from a fund that Sandra will hold.

Give date of first session and suggest she **come half an hour earlier** for the first group e.g. 9.30 for coffee, to start promptly at 10.00. Point out the problems if people arrive in dribs and drabs (especially for the first meeting) both for them as latecomers and for the group that can't get going.

Initial meeting.

1* Introduction

- *Rationale for today's meeting**

- *Research aspect**

- *Initial reactions**

2* Orientation

- *Course content ,rationale and working model**

- *Course structure**

- *Course format**

- *Group composition**

3* Assessment.

Literacy/ comprehension

Mood /distress

E.P.D.S.

4* Engagement

***Interest**

***Concerns**

***Problems in coming**

5. Separate :5 mins each alone with you. (if appropriate)

6* Summary

***Summary**

***Practicalities, dates,travel expenses.**

Agenda : Session 1

Becoming a mother: what does it mean for me?

Starting off

Introductions
&
Arrangements

Motherhood

Images of motherhood

What motherhood means for me

Transitions and reducing stress



Thoughts

Common errors

Altering how we think

Self talk

Feedback and self help exercises

Session 1

Becoming a mother :What this means to me

Goals:

1. For the group to form and begin to develop a climate of openness, trust and interest/inquiry.
2. For the participants to consider what motherhood means for them.
3. For the participants to understand the importance of cognitions in emotional well-being, and to examine some of their own thoughts in relation to their pregnancy/motherhood.

Materials:

Flip chart and pens.

Name badges.

Paper and pens.

Files.

Posters:	Agenda 1	Thinking errors Changing thoughts Images of motherhood pictures
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Handouts:	Agenda 1	Thinking errors Transitions Changing thoughts
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Self help exercises worksheets

Post session forms

Main emphases of session:

Thoughts

Information

Sharing

(There is a lot to include in this session and people may arrive a bit late. Suggest you start introducing people to each other informally, and encourage them to use the waiting time for getting to know a bit about each other, writing name badge etc. Provide some books and magazines about motherhood for them to browse through.)

1* Welcome and outline today's agenda.

2* Introductions and rationale.

"Why are we all here today?" (Offer rationale; i.e. "all starting a 'new job' for the first time, facing new experiences and challenges. It requires major adjustments and a lot of new learning ;we hope this course will help with this and will also reduce the associated stresses and strains ,both now and in the future. This is a chance to say everything you always wanted to say about pregnancy and motherhood but didn't dare. In particular the group will address the issue of Post Natal Depression, what it is and ways of preventing it".)

"Let's introduce ourselves....." (*Suggest:they turn to their neighbour, exchange names and spend a few minutes telling each other something about yourself e.g. due date, something you enjoy doing, something you enjoy about being pregnant, where you live....*

:two pairs join up, swap names, introduce your "partner"

:as a whole group, share names and anything else anyone would

like to say at this point.)

Acknowledge that it will take a while for people to get to know each other and for the group to get going.

Point out that we hope this group will itself be supportive,and invite them to think about how they can get the most out of it.

Elicit hopes and concerns about the group sometime in the session, if it feels helpful.

Acknowledge similarities and differences that exist within the group at some point in the session.

e.g. “It may be helpful in getting to know each other, to discover things you have in common and also ways in which your lives are different. Whilst you are all alike in that they are expecting your first baby, each person’s circumstances and feelings about the future are different e.g. discovering that you were pregnant may have been wonderful for some people, brought mixed feelings for others, and been a shock/horror/disappointment to others. Similarly, some people will have a partner and feel pretty well supported, some will have a partner but not feel supported, others will not have partners etc. *(adjust content depending on the group’s members e.g. different ages, walks of life, ethnic backgrounds)*. We are individuals: what’s easy for one person, or suits one person, isn’t necessarily so for another. So as we talk together here, we need to be careful not to make assumptions or judgements about each other. But equally, you’ve all got a lot to offer each other, and the more open we can be with each other, the more we can discover” etc.

3* Practical arrangements and “ground rules”.

Briefly remind of times, dates, partners’ meeting etc.

Explain coffee arrangements, where toilets, phones are.

Ask them to phone if not coming so that people don’t worry if they’re all right, and so we can organise a set of handouts for them.

Agree confidentiality :suggest personal and identifiable material is confidential within the group sessions; general themes are O.K to discuss and share outside the group, and indeed it may be helpful to do this.

Encourage them to phone you between sessions if something comes up about the course that is troubling them to the extent that they are not sure they want to come back.

N.B. if people arrive late, fill them in at coffee time: you won’t have time to repeat items.

4* Motherhood.

***Images of motherhood.**

“How we feel about ourselves as mothers, the expectations we put upon ourselves, and what we predict for the future, are strongly influenced by our images of what a mother is or should be. Our beliefs about how she should behave, what she should look like, how she should sound, what she should feel, etc. are the result of a mixture of influences. These include T.V., magazines, stories, music, but most

importantly, our own experiences of our mothers and the people who “mothered” us . It’s important that we are at least aware of these influences, and understand how they can get to us , whether helpfully or unhelpful.”

****Exercise: “Let’s think up all the ‘images of motherhood’ we can” .(Try to include some of the following and use pictures if it helps)***

“perfect housewife: in control of everything, no mess”

“earth mother”

“Madonna”

“old mother hubbard”

“chained to the kitchen sink”

“the juggler”

“How do these images of motherhood effect us ?”

e.g. they focus on the mother, as if it’s all her responsibility, excluding men often.

e.g. they can set up internal standards that you may try to meet ,and of course fail, which then undermines your confidence : “I’ll never be like that , I’m not good enough”

e.g. they can give you false ideas about how you ought to feel :”I don’t feel like that, there must be something wrong with me”

e.g. they can leave you with feelings of shame or guilt for not being like the images

e.g. they may set up expectations in others about how you should be, which don’t fit you.

e.g. they can make you feel helpless, no point in doing any thing since” I’ll never in 100 years be like her”

e.g.

“How do we protect ourselves from the unhelpful aspects of them?”

“Knowing them for what they are i.e. only images not realities. Recognising when we are being influenced by them. Getting to know more about the realities by talking to and spending time with women who have children. And

***What does being a mother mean to me?**

“Let’s think a bit more about ourselves as future mothers. The sorts of stresses and strains we may each feel will depend in part on what this new role means for us.”

**Exercise: Think about what “becoming and being a mother” means for you. Individually write down the first 5 things that come into your head : UNCENSORED.*

Keep the list for later: we’ll come back to it.”

***Losses and opportunities.**

“Some of the things you will have written down on your lists will be to do with losses that you associate with motherhood, and some will have been to do with opportunities, new experiences. It’s important to acknowledge both aspects.”

**Exercise: “Let’s draw up a list of all the -ve and +ve aspects of being a mother we might experience.” (Write examples up on flip board. Try and draw out some examples that are +ve for some women and -ve for others e.g. larger breasts during pregnancy, leaving work, being at home more.*

Also try and identify examples that are +ve sometimes and -ve at other times e.g. baby kicking.

Elicit examples that cover physical, social, work, partner and close family, financial/housing, status/ how they value motherhood.)

This exercise may need extra care and sensitivity to avoid those with low self esteem feeling divided from the more dominant or confident group members.

“So this experience of being a mother means very different things for different people. The balance of upside to downside differs, as does the importance of particular things over time.

If you tended to only see +ve or -ve aspects, write down some points that balance the picture for you. Remember that these are only predictions about what might happen, they are not certainties.”

***Transitions and reducing the stress.**

Briefly introduce the idea that they are going through a major change in their lives, which can be exciting and interesting, but also unsettling and unnerving. Point them to the handout, especially the section about ways of easing the transition, and invite a discussion about this if there is time.

5* Cognitions.

You will need to judge for yourselves whether you will need to simplify the language and drop the "jargon" and even the posters, depending on the group members.

"In this part we want to invite you to think about how you think. i.e. your cognitions."

***Importance of cognitions in emotional well-being.**

"How we talk to ourselves and the way we think about what's happening, to a large extent determines how we feel. So, being aware of how we think about the world and ourselves, finding ways of altering them if they are making us feel stressed/ down can have a major impact on how we feel.

Altering how you think is a very powerful way of taking care of yourself.

For example:

the midwife says "it looks like you're going to have a big baby". How you feel about this will depend on what this means to you and what else you say to yourself e.g.

"Oh hell, that means the birth will be even harder" ⇒ worry, increased fear.

"Great, then she must be growing well" ⇒ feel confident in self and baby.

"Oh no, I've just bought loads of first size clothes; what a waste of money; typical of me to get it wrong again" ⇒ sense of failure, annoyance, resentment.

"So that's why I'm feeling so huge and tired; maybe I'm not such a wimp after all" ⇒ relief and increased confidence.

"I bet it's going to be just like its dadbig, bullying and demanding" ⇒ -ve att. to baby.

.....big, happy and easy going" ⇒ +ve att. to baby.

***Erroneous ways of thinking. (Omit the "jargon" if not appropriate to the group.).**

We all think beyond what's actually been said/happened; that's normal. BUT if we make certain types of distortions or errors in the way we are thinking, we can create all sorts of problems for ourselves.

Common types of errors:

1. **over-generalizing** e.g. since the baby slept through last night, it always will sleep through the night.
e.g. I've had morning sickness and I'm putting on weight, so this pregnancy and birth is all going wrong.
2. **catastrophizing** e.g. I'll die of embarrassment if my dad comes in when I'm breast feeding.
3. **all or nothing thinking** e.g. either I have a totally natural birth or I'm a failure.
4. **selective remembering** e.g. I've not had a single good /bad day since I've been pregnant.
5. **jumping to conclusions** e.g. because mum isn't pleased about me being pregnant, she won't help me with the baby.
6. **misattribution** e.g. it's my fault that is going to happen,(when it's not)
e.g. it's the baby's fault that we are unhappy,(when it's not)

***Altering how we think.** (*Omit "jargon" if not appropriate to group.*)

"As we said before, changing how we think is a very powerful way of improving how we feel. There has been an enormous amount of research done in this area over the last 20 years, which shows that people can be very effective at improving how they feel by altering their cognitions (thoughts)."

"So how can we alter how we think in a way that is more helpful to us?"

"Here are some ways that have been found to be helpful:

1. **Identify your automatic thoughts** (your own inner voice) e.g. when something goes wrong what do you automatically say to yourself, without even realising it? (*Give or invite examples, depending on time.*)
2. Once you have identified these unhelpful thoughts, you can set about **challenging the thoughts**. i.e. what's the evidence, other ways of seeing it, test it out. (*Give an example from something someone has mentioned if possible or from the errors list*)

Other ways of changing how you think about things are the following:

3. **Re-focus** e.g. on the +ve as well as the -ve (as we did when thinking what motherhood meant for us)
 . If you really can't find anything positive now to focus on ,it can help to remind yourself about the future.
 4. **Reattribution.** e.g. "are we really rowing because of the baby or is it more to do with making a commitment to each other, worry about money, the usual struggles we have about who decides things?"
 5. **Re-frame** e.g. "I've got to change just when I'm very settled. ⇒ this pregnancy is a chance to get out of old ruts , learn new things, see if I like doing something different with my life more than I thought"
- e.g. "oh no, the pregnancy means I'll have to talk to my dad again.⇒ This will give us the chance to see if we can get on any better now; maybe a baby will break the ice"

***Self talk.**

"Self talk i.e. what we say to ourselves about ourselves, is very important in determining how we feel about ourselves and how we face difficult situations.

e.g. "I can't cope - I'm no good at this" "I'll never be able to" "No-one will want to help me"
 "I shouldn't feel like this ; there must be something very wrong with me" "I ought to be able to do this alone; I mustn't trouble anyone" ⇒ feeling NOT O.K. about yourself e.g. inadequate, no confidence, low self esteem etc.

e.g. "This is tiring, I'll see if someone else can help me out" "that was tough but then it was the first time. I did pretty well really" "I find ... difficult, but is easy enough now" "I need to remember that I've done things like this before and come through" "It may not be brilliant , but it will do for the moment" "I'm feeling very uncertain, but that's normal in this situation" "I'm feeling overwhelmed, so I need to go slow and deal with one thing at a time. That way I can deal with it" "I'm good at keeping going; I'll need that now" ⇒ feeling O.K about yourself.

"Learning to develop helpful, encouraging self talk is something we will come back to throughout this course, since it is a simple yet very powerful way of taking care of ourselves emotionally."

***Exercise:** *“Let’s practice trying to alter some of the unhelpful ways we think.*

Look at the list you made just before the coffee break, of what becoming/being a mother means to you . What do you notice about the 5 things you wrote? e.g. Are they all -ve or all +ve ? Are they all to do with how you are feeling now or how you expect to be in the future? Do they focus on you or other people? Are they based on “images “ of motherhood? Are they to do with hopes and fears?

Would anyone be willing to share some of the things they wrote? Which ones would you like to alter? (Use them to illustrate errors of thinking and as a way of addressing adverse reactions to pregnancy. Encourage participants to try ways of altering their thoughts to be more helpful.)

6*Feedback and self help exercises.

***Feedback.**

“At the end of each session we will ask you to give us some feedback about the meeting, and also to spend a couple of minutes filling in this form before you leave. The reason for this is so that we can learn from your experiences and reactions. We also need to make sure that we are putting across what we are intending to , and so we too have to fill in a similar form ;you’ll see us doing that at the end while you do yours. We don’t get to see what you write down at this stage, so if you want us to know something ,you need to say it to us. These forms are for the research part only.”

Invite feed back on today’s session : check out whether anyone is feeling overwhelmed by it all, criticised, etc. Is it very different from what people expected?

Make some encouraging comments e.g. about having made a good start, congratulations for keeping going through a long and very full meeting, it is just the beginning and it will take a while to get to feel comfortable together and for your particular concerns to get addressed etc.

***Arrange self help exercises.**

“Our last task for today is to suggest something to do at home that helps you to build on what we’ve started today. The reason we strongly suggest you do these small self help exercises is so that you get the most out of this course. It’s often only when you come to do something yourself after the session

that you suddenly realise how it's relevant to you, or you realise you don't have a clue what it was about, so you can ask us next time."

"We'll also give you a series of handouts each time that cover many of the things we've talked about that week. Here they are: there's one on and one on etc. We suggest you read them through sometime in the week, underline bits that seem relevant if you like, and feel free to show them to partners/friends if you want ."

"This file is for you to build up and keep; bring it each week and you can add to it anything you find useful, and it will be there as a resource to you long after the end of this group."

"For this week's self help exercise, we would like you to note down examples of the errors in your thinking that you notice as you go about your lives. Try and develop an "ah ha" sense. There is a worksheet to do this on in your file.

Secondly, try changing some of those distortions using some of the ways we've discussed. There's another worksheet to help you with this"

"Bring them back next week , especially if you have trouble with it"

" Any questions? Bye ,see you next week"

****(Distribute and complete /collect post session feedback forms)***

(Complete course leaders' forms)

Session 1 : Cribsheet.

Becoming a mother :What this means to me.

1* Welcome and agenda.

(Poster)

2* Introductions and rationale:

3* Practical arrangements and “ground rules”.

4* Motherhood:

***Images of motherhood (Pictures)**

***Exercise:** *"What are the images of motherhood?"*

"How do they effect us?"

"How do we protect ourselves from them?"

***What does being a mother mean to me?**

***Exercise:** *"What does being / becoming a mother mean to me? Write down the first 5 things that come into your head, uncensored."*

***Opportunities and losses.**

***Exercise:** *"Positive and negative aspects of motherhood"*

5* Cognitions:

***Cognitions and emotional wellbeing**

***Erroneous ways of thinking (Poster)**

***Altering how we think (Poster)**

***Self talk**

****Exercise: Share "5 thoughts on motherhood" and practice ways of changing thoughts.***

6* Feedback and self help exercises

***Feedback**

***Self help exercises**

- *1. Notice and record own cognitive errors.
- *2. Practice trying to change a distorted thought and record.

***Post session forms.**

*Participant's

*Course leaders'

Checklist: Session 1

Becoming a mother : What this means to me

Tick the box as each item is covered.

(Allow 30 mins for 1-3)

1. Welcome and agenda.....
2. Introductions and rationale.....
3. Practical arrangements and “ground rules”.....
4. Motherhood: *(allow 30 mins)*
 - Images of motherhood. (Exercise).....
 - What does being a mother mean to me? (Exercise)....
 - Opportunities and losses. (Exercise)
 - Transitions and reducing the stress.....
5. Cognitions: *(allow 30 mins)*
 - Cognitions and emotional well-being.....
 - Erroneous ways of thinking.....
 - Altering how we think.....
 - Self talk.....
 - Exercise: Altering how we think.....
6. Feedback and self help exercises: *(allow 15 mins)*
 - Feedback.....
 - Self help exercises.....
 - Post session forms.....

Transitions

Transitions are times of major change in our lives. You've been through many already, e.g. being born, starting school, changing from a child to an adult (adolescence), getting your first job. At the moment, being pregnant with your first child, you are going through another transition, to motherhood.

This involves a huge number of changes, e.g. our bodies change dramatically, we may change the way we see ourselves as women, in our work and in our friendships. There will be changes within our families and most importantly in our relationship with the man who is now not just our partner, but also the baby's father. There will be changes in what we do with our time, the sorts of things that concern us and our sleep patterns.

Those close to us are also having to adjust, both to their new roles (e.g. as father, or grandparent) and also the new "us".

Not surprising then that this can be a time of stress and emotional upheaval. Your expectations of yourself and others may change, your view of the future and your priorities change, and you will have to learn a range of new skills and face a number of new people and experiences (health workers, the birth, etc.).

There are some things we can do to make the transition smoother or less stressful for ourselves:

1. Being prepared for the change and realistic in our expectations. Thinking ahead, meeting with parents of young children, spending time with babies, all help with this.
2. Getting support in all its forms:
Practical help
Emotional Support and encouragement
Information, advice and guidance
Companionship
3. Approaching the changes positively and being active in influencing how you want things to be.
4. Keeping the number of changes to a minimum, e.g. avoid home and job moves or taking on new projects. Try and keep some stability and familiarity.
5. Allow yourself time to adjust. Be understanding of the stress you are under and don't underestimate the energy it all takes.
6. Take care of yourself physically and emotionally, e.g. make time to relax, eat well. Bolster your self-confidence and self esteem, which can often feel shaken at these times.

Look back over these six points. Underline the points that would be useful for you to remember.

Common types of errors in thinking.

1. **Overgeneralizing** :e.g. since the baby slept through last night, it always will.
e.g. I've had morning sickness and I'm putting on weight, so this pregnancy and birth is all going wrong.
e.g. After being rushed by one doctor, deciding that all doctors are in a hurry.
2. **Catastrophizing** e.g. I'll die of embarrassment if my dad comes in when I'm breast feeding.
e.g. It will be awful if I have to have a Caesarean.
3. **All or nothing thinking** e.g. either I have a totally natural wonderful birth or I'm a failure.
4. **Selective remembering** e.g. I've not had a single good day since I've been pregnant.
e.g. my partner never helps me.
e.g. my mum was always there to look after us.
5. **Jumping to conclusions** e.g. because mum isn't pleased about me being pregnant, she won't help me with the baby.
e.g. because I didn't like my friend's baby I won't like my own.
6. **Misattribution** e.g. it's my fault that is going to happen (when it's not)
e.g. it's the baby's fault that we are unhappy (when it's not)

Which of these types of errors do you often make?

What's the effect on you of making these distortions?

Changing how we think.

Changing how we think is a very powerful way of improving how we feel . We make all sorts of assumptions, predictions and errors in the way we think.

Here are some ways that are helpful in altering how we think:

1. **Identify your automatic thoughts** . When something goes wrong , what do you automatically say to yourself , maybe without even realising it? e.g. “just typical, things always go wrong for me”, or “that’s another sign that I’m no good at things”.

Once you have identified these unhelpful thoughts, you can set about **challenging the thoughts**. i.e. what’s the evidence ?

what are other ways of seeing it?

test out whether your assumptions are accurate.

Other ways of changing how you think about things are the following:

2. **Refocus:** notice whether you are focussing on just one side of things , and if you are, deliberately make yourself focus on the other side too i.e. notice the positives as well as the negatives (as we did when thinking what motherhood meant for us) . If you really can’t find anything positive now to focus on, it can help to remind yourself about the future.
3. **Reattribution:** challenge whether the way you are understanding the situation and attributing the “blame” is accurate or helpful. e.g. “are we really rowing because of the baby or is it more to do with making a commitment to each other, worry about money, the usual struggles we have about who decides things ?”

e.g. “is the baby really trying to annoy me, or is it that she’s crying and I ’m tired and don’t know what’s the matter with her?”

4. **Reframe** . This means changing the way you think about something , reconstruing it into something positive. e.g. “ Oh no, I’ve got to change just when I’m very settled ” ⇒ “This is a good chance to get out of old ruts , learn new things, see if I like doing something different with my life more than I thought .”

e.g. “oh no, the pregnancy means I’ll have to talk to my dad again” ⇒ “ This will give us the chance to see if we can get on any better now; maybe a baby will break the ice”.

Changing Thoughts

<u>First Thought</u>	<u>How I altered it</u>
e.g. "Mum's angry with me because she has not phoned"	What evidence is there she's angry? None What are other ways of looking at it? Phone's not working/ she's busy/ she's got nothing to phone about/ she did phone but I was out/ she's saving money and not phoning Test it out - ask her if she's angry with me and if so what's it about?
1)	
2)	

Agenda : Session 2

Ways of Coping

Feedback and review of self help exercises

Coping styles



Personal Problem Solving

(The S.O.D.A.S model)

Next week's meeting

Feedback and self help exercises

Session 2

Ways of coping

Goals:

1. for the participants to understand the SODAS problem-solving model, and for the group to work through an actual example.
2. for the participants to become aware of their own coping styles.
3. for the participants to begin thinking about social support and the communication skills involved in developing the support they may need.

Materials:

Flip chart and pens.

Posters: Agenda 2

Coping styles

SODAS model

Handouts: Problem- solving

Problem-solving exercise sheet

Copies of posters

Post session forms.

Main emphasis of session:

Problem-solving

Some attention to social support.

1* Welcome back and outline agenda:

“Any other burning issues to add to today’s agenda”? (*Write down and identify where they might come in e.g. either today as an example later in the session, or another week*)

2* Feedback and self help exercise review:

***Feedback.**

“Anything left over from last week’s meeting we need to talk about.”

“We realise that there wasn’t much chance last week for you to talk : we talked a lot. As the weeks go by there will be more and more opportunity for you to be involved, but we are keen to put across a lot of ideas in a fairly short time.”

“How are you feeling in the group? Still rather new? Is it beginning to feel safe enough to say what you think? What would help?”

***Review of self help exercises.**

This session , take time to check out problems with the exercises, especially if people are not doing it. Repeat rationale and benefits to them, problem solve any difficulties or worries e.g. not getting it “right”, not understanding the task but not daring to ask.

“What did you discover from the exercises about the sorts of errors you make?”

“How did you get on with challenging a thought?”

“For those who didn’t do the exercises, do you know what stopped you? What do you need to help you do the next self help exercises ? It’s not that you’ve got to do it, of course you don’t, but we are concerned that you get the most that you can from this course, and we’ve learned how important doing these sort of exercises is in the long run. The more you get involved and the more you put into it , the more you’ll go on getting from it in the weeks and months to come”

3* Coping styles.

“We all have different ways in which we cope with problems and crises. There are no absolutely right or wrong ways, although some ways work better in some situations than others. What is useful, is to be aware of our own styles and the strengths and pitfalls of that way of coping, so we can be one step ahead of ourselves. Also, if we’re aware of other styles of coping we can start learning these.”

***Identifying own coping styles:**

Present Coping Styles poster and ask participants to identify their usual styles.

***Advantages and disadvantages of different styles:**

Exercise : “Let’s think about some advantages and disadvantages of these styles”. (Invite group’s ideas ; include the occasional advantages of avoidance/wishful thinking in that sometimes problems resolve themselves. But stress the dangers of these styles particularly with something that will not go away (like a baby), and when problems may come to a head just when you are least able to cope. Also they are very passive ways of dealing with the world and do little for your self esteem and confidence. Useful to be able to call on a range of ways of coping e.g. being able to seek support at times, to cope with the problem and to cope with your own feelings when necessary. Similarly there is a place for wishful thinking and avoidance, e.g. as a way of giving you a rest from the problem, as long as you are aware of what you are doing , and don’t believe that you can wish away a problem.)

*** Coping and social support.**

“Seeking support is often a very effective way of coping, and that support comes in many forms e.g. practical help,

emotional support (being listened to , feeling understood, being encouraged etc)

companionship (someone to go through it with)

getting information and guidance you can trust.

(Point out that an important way in which this group can help them is through the support it can offer them.

Emphasise that communication skills are needed in order to get the help you need e.g. asking for the help or information you need ,or declining requests for help. Explain that we’ll look at this more in Session 4 and 5.)

4*Personal problem solving.

***Rationale :** “Why are we talking about personal problem solving in this course?”

“It’s a way of coping : one that has been shown to be extremely helpful in dealing with everyday life problems .It stresses the importance of planning your own life rather than it

planning you. It offers a way of approaching problems that gives you the best chance of working out the best solution for you. In the months ahead you are bound to be faced with a whole range of new "problems"; however well prepared you are you can't sort everything out in advance. But you can have a WAY of dealing with problems sorted out for yourself in advance. That's why we are wanting to talk about this here: it's another way of preventing strains and stresses"

***Explain the SODAS model using the poster.**

STOP: Problem recognition and clarification. Be specific. Come up with a clear statement of what the problem is, in a way that does not imply a solution. Positive attitude to problems: dealing with thoughts and self talk that exaggerates the problem or reduces your confidence to deal with it.

OPTIONS: come up with as many possible solutions as you can. Be creative. Don't criticize your options. Think of ways that include changes in what you do, your thoughts, and the situation.

DECIDE: Work out which option is likely to be the best one for you. Look at for's and against(costs); the likely effect on yourself and others; short term and long term impacts; the amount of energy required and available.

ACT: Work out the steps involved, and then do it. It may help to practice bits first or get help from others if this is something new.

Self PRAISE and evaluation: Praise yourself for completing each step as well as for the successful outcome. Assess how well your plan worked: notice areas which have changed for the good and those where it has not worked. Adjust your plan or how you did it, and decide when you will have another go.

(Illustrate with an appropriate sample example as you go through the model.)

****Exercise: Let's work through together a problem that someone is facing at the moment. Who would like to volunteer a problem that we could look at together using this model?***

(If no-one offers, recall something that has already been mentioned and ask if we could use that as an example. Or ask if anyone has a problem about their partner/mother/friend coming to next weeks meeting)

5*Remind about next weeks meeting .

"Next week's meeting is for "partners" also . That means the person who will be your main source of help during your pregnancy and the first few months with the baby. Have you decided who to invite? any "problems" about them coming?" *Explain there'll be videos, information about PND , and a male colleague present.*

6*Feedback and self help exercises.

****Invite feedback and questions about today's meeting.***

****Organise self help exercises.***

1. Talk with "partner" about coming next week. Explain to your partner why it's important to you that they come and what you hope you will both get out of it . Explain to them about the SODAS model. *(i.e. a communication exercise).* Reassure those with no-one to invite, that they're not going to be left out of the session.
2. Identify a current difficulty and work through the problem solving exercise sheet.

Distribute handouts.

****Distribute and complete/collect post session feedback forms.***

****Complete course leader's forms.***

Session 2 :Crib sheet.

Ways of coping

1 * Welcome back and agenda.

(Poster)

2* Feedback and review of self help exercises

3* Coping styles:

***Identify own coping styles (poster)**

***Advantages and disadvantages of styles**

****Exercise: "Let's think about the advantages and disadvantages of each style"***

****Coping and social support.***

4* Personal Problem -solving:

- *Rationale**

- *SODAS model (Poster)**

- *Work through an example.**

5* Next week's meeting. (Partners invited)

6* Feedback and self help exercises.

- *Feedback**

- *Self help exercises**

- *1 Talk with partner about coming next week, say why it's important and what you hope to get out of it (communication exercise). Explain the SODAS model to them.**

- *2 Identify a current difficulty and work through it using the problem solving sheet.**

- *Post session forms.**

Checklist: Session 2

Ways of coping

Tick off items as they are covered.

1. Welcome back and agenda.....

2. Feedback and review of self help exercises (*Allow 15 mins*).....

3. Coping styles: (*Allow 30 mins*)

Identify own coping styles.....

Advantages and disadvantages of styles. (Group Exercise)....

Coping and social support.....

4. Personal Problem -solving: (*Allow 40 mins*)

Rationale.....

SODAS model.....

Work through an example.....

5. Next week's meeting.....

6. Feedback and self help exercises: (*Allow 15 mins*)

Feedback.....

Self help exercises.....

Post session forms.....

Coping Styles

Wishful thinking:

e.g. hope for a miracle to change things, daydream of a better situation, wish you could change what's already happened.

Seeking Support:

e.g. get help from someone, talk to someone.

Avoidance:

e.g. pretend there is no problem, reach for the bottle, cover up how you feel so no one can tell anything's wrong.

Coping with the problem:

e.g. take things one step at a time, work out a plan and do things steadily.

Coping with feelings:

e.g. accept your feelings are natural in the situation, try not to worry over things you cannot control, tell yourself you will come through.

My usual coping styles are

Personal Problem-solving

Solving personal problems is a part of everyone's life. One of the most stressful experiences is having a problem so huge or confusing that you don't know where to start. You may need to step back, take a long hard look at the whole situation, and do some problem solving.

School may have taught us how to solve maths problems, but it doesn't usually give us a model for solving personal problems.

S.O.D.A.S is a way of problem solving that people have found useful in everyday life situations. It's useful as a way of approaching major problems and the more ordinary everyday difficulties.

S.O.D.A.S stands for:

S = Stop: What's the problem?

O = Options: what possible solutions are there?

D = Decide: which option is most likely to be the best one

A = Act: work out the steps you need to take and go ahead

S = Self praise and evaluate: Praise yourself for completing each step. Notice how well your plan has worked.

You may already do parts of the S.O.D.A.S process without realising it, but it may be helpful to go through the different steps in order to find the best solution for your particular problem. This is especially true when you are under stress, because at those times our emotions often taken over and colour our thinking , and we tend to jump to solutions too quickly. The "solutions" we come up with often don't really solve the problem.

So what does each stage in the S.O.D.A.S. process mean:

STOP

Stop and identify the problem. This can be the hardest part of problem solving either because we don't want to accept that there is a problem, or because we're in too much of a hurry to solve it. Remind yourself that it's helpful to be aware of the problems we are facing, and the sooner we face them the easier and quicker it is to solve them. Putting them off only gives them the chance to get more complicated and often makes us exaggerate the problem so that it becomes more threatening and difficult to deal with.

- Some problems are obvious, but others aren't. We may need to listen to our bodies, our feelings and our self talk to identify that something is bothering us. "Red flag" signals that warn you when you may have a problem include:
Symptoms such as headaches, tension, feeling irritated, crying, feeling flat, weary.
Self talk that focuses on phrases like "I must", "I never", "I should".
- Be clear about exactly what the problem is. A broad statement e.g. "I'll never cope", is difficult to deal with. Try and be specific; think about when, where, with whom, the problem exists and what it is really about, e.g. is it really that you can't "cope" or it is that someone else thinks you are not doing things in the way they would.
- Be careful that the way you define the problem doesn't suggest a solution, since this limits your possible solutions. e.g. if you define the problem as "I need my mum to look after the baby and she won't", you rule out options of getting other people to look after the baby, who might be much happier to do it.

Options

Think of as many options (possible different solutions) as you can. It's more helpful to come up with lots of options, however unlikely they sound, than just to go for the first one that comes into your head. Let yourself be creative, keep an open mind and think up a range of different options.

If you find this is difficult to do, it may help to look at the situation in terms of how it could be changed. e.g. suppose I am worried about managing financially on a very limited budget, when the baby arrives. Possible changes I might consider could include:

- 1) changing what I do now e.g.
 - save anything I can now; only buy what's essential for the baby; borrow what I can.
 - find out how other people manage

- find out about all possible benefits
 - ask people to give the baby something it really needs not another soft toy.
- 2) changing my thoughts e.g.:
- use self talk to change “I won’t be able to cope”, to “I can look after our basic needs for food, warmth and love. I’ve done this for myself, I can do it for both of us; ok we won’t have the frills but we can survive”. (listen to Gloria Gaynor’s song “I’ll survive”).
 - or I might focus on the future, reminding myself that it’ll be easier when:
 - I can get some part time work
 - there are changes in the benefit system
 - my partner gets a job/can get overtime/promotion
 - it’s summer and there are no heating bills.
- 3) change the situation
- hand over responsibility for balancing the money to someone else e.g. my partner.
 - take out a huge loan
 - steal a large sum of money
 - marry someone rich

These are just some possible options. Remember, don’t criticise your options, let yourself come up with as many as possible at this stage.

Decide

The third step is to decide on the best option. Your decision is based on what you think is important, how much energy you want to put into it, what you think will happen if you do each option - of course you can’t be sure what will happen, but you can often make a pretty good guess (but be careful not to always assume negative outcomes).

It may help to ask yourself:

1. Which options can I really do?
2. How would each option effect me and the other people involved?
3. What are the short term and long term effects.

Another way is to make a list of the “fors” and “againsts” .

Action

Once you've made the decision, it's time to act. This may not be so easy if it is something you've never done before. It may help to break down what you need to do into smaller steps. This is less frightening and gives you the chance to praise yourself at each step. You may need to talk to yourself in a way that builds up your confidence and reduces your worry. It may also help to "practice" what you're going to do/say first on your own, so that you can get more comfortable with it.

Self Praise and evaluation

Be sure to praise yourself for your efforts , as well as for succeeding at each step. You may want to give yourself a treat or 'present' when you've accomplished your goal, or at steps along the way to keep you going.

Then step back and see how your plan has worked:-

- what's changed for the better, what hasn't?
- do I need to be alter my plan or alter how I behave (e.g. firmer)
- do I need to try again?

If your plan hasn't worked, remember that things often don't work the first time .So don't give up, but decide when you will be ready to have another go.

S. O. D. A. S.

Stop

Options

Decide

Act

Self praise and evaluate

PROBLEM SOLVING WORKSHEET

Stop

Identify a "problem" you are currently facing:

What exactly is the difficulty?

Options

Brain storm possible options.

Decide

Decide which seems best to follow through.

Action

Plan how and when you will do it (break it down into small steps)

Self praise

Plan how you will tell if it has worked and how you will praise yourself for your efforts

Agenda : Session 3

Life with a new baby

Video 1: Bringing the baby home

Discussion

Group exercise

Problem solving



Video 2: Post Natal Depression

Discussion

Ways of preventing Post Natal Depression

Getting help

Feedback and self help exercises

Session 3.

Life with a new baby.

Goals:

1. for the participants to learn about post natal depression and sources of help.
2. for the participants to think about potential “problems”, and to communicate with partners about them.
3. for partners to appreciate the benefits of joint problem solving.
4. for participants to engage in support enhancing exercises .

Materials:

Flip chart and pens

Video machine

Videos: “Bringing the baby home”

“Post natal depression”

Posters: SODAS

Preventing post natal depression

Handouts: Problem -solving worksheet

What to remember worksheet

Leaflet on post natal depression

“Preventing post natal depression” handout

Post session forms (for partners too)

Main emphases:

Information

Sharing

Some attention to social support.

Role of the male course leader in session 3.

1. To identify with the male partners and to help them express their concerns and perspective. This might involve suggesting some feelings or worries they might be having, to share how difficult it can be to feel marginalised, “pushed out” or helpless/ unsure about how they can help.
2. To encourage the male partners to take an active role in the session, and to model how they can be involved in a group that they are new to (so are you!).
3. To model how you and the female course leaders can work together collaboratively, by helping each other out, adding your own perspectives, experiences and skills, and respecting each others’ contributions. So being open in your communications with your co-leaders, “sharing” the session, asking each other for help, is all good modelling.

I have written into the manual specific items for the male leader to be responsible for. This does not mean they should be quiet at other times ! It was intended that as the session progressed the leaders might find it easier to work out their own balance about who leads each bit, but that early on in the session , it makes sense for the male leader to share the introduction and welcome, introduce the video, and facilitate the group discussion with the partners. Thereafter, be flexible about the balance, but sensitive to making a place for all. There is a very clear parallel for the participants: how do they enable each other to have a role in parenting and to contribute in a way that is beneficial to both of them and the baby; It may be that they will want to think about specific things that each of them will be responsible for, at least initially, and to develop clear communication so that they can tell each other about their needs and feelings, and changes that come about.

1* Welcome and rationale:

Male and female course leaders present this part. Male might acknowledge how odd it feels to come into a group that already knows each other.

“ We appreciate the effort you have made in coming today; we hope the session will be helpful. The reason for inviting you all is that , as you will have already realised, the arrival of a baby effects more than just the mother; you will all be very important in contributing to how the next months go. Some of you will be becoming fathers for the first time, some of you grandmothers for the first time etc. It's a time of change all round; joy and excitement, but it can also put considerable strain on all concerned. Experience has shown that the more people are prepared for what may be ahead, and the more they can recognize and talk to each other about what is difficult/ stressful, the less strain they experience. We've discovered that it's worth thinking now, before you're under stress, about how you can best support each other through tough times. When 2 people are under pressure, as often happens after a baby is born, it's easy to feel got at, and get into blaming each other rather than helping each other. It's often hard to step back and look at things clearly at these times, so we invite you to start doing this today .

So, today is a chance to stop and think about yourselves, to share common concerns, and to prepare for what may be ahead. We'll use 2 videos as starting points; the first one is about some parents' feelings and reactions on bringing the baby home and in the first few weeks. The second one is about postnatal depression. We are including this since it's a not uncommon experience, and it's important that you are able to recognize if you or your partner or your friend are depressed, so that you can get the help you need quickly.”

2* Agenda:

(use poster to outline today's agenda)

3* Video 1: “Bringing the baby home”

(Show video) Male course leader introduce the video.

***Exercise:** *Brief group discussion of points that they found interesting/surprising.*

Flip chart themes e.g.

- anxiety on arriving home
- dealing with physical discomfort/pain
- feeling inadequate/ no confidence
- feelings of responsibility/restriction
- feeling left out/unimportant/undervalued
- emotional sensitivity/vulnerability and misinterpretation
- establishing routines (regulator vs facilitator)

***Exercise:** *If 2 or more partners present split to form groups i.e. pregnant women (With female leader) : fathers to be (with male leader): grandmothers to be/others.*

“ We would suggest you discuss together what you think may be sources of strain/conflict/worry for you , in those early weeks. Would somebody in each group write headings on flip chart of the sorts of things the group is identifying as likely difficulties e.g. money, feeling tired, dealing with work and home demands, managing relatives, sex, feeling resentful, being involved/not taking over etc.” (Leaders facilitate discussion within the small groups. (10 mins approx). Reconvene large group and pin up flip charts and share. Help the group identify common areas and complementary concerns)

***Exercise:** *“Now , while it’s still fresh in you minds , talk with your partner about those points that you think may apply to you two. Talk about how you might be able to help each other.”*

If no partner present ,invite them to think which things might apply to them , and who they might talk to about it.

4* Problem solving as a way of coping.

“What you’ve just been doing i.e. identifying problems, and thinking about ways of dealing with them, is all part of problem solving. We solve problems all the time in our lives, but often we can rush into finding a solution without giving ourselves time to be clear about what the actual problem is, or time to consider a range of solutions. On the course we’ve been looking at a way of problem solving and we’d like to invite partners to give it a try too. Partners, what have you been told about this model?It’s particularly helpful in approaching emotionally charged problems, and helps you look at a “problem” jointly, without accusing each other or neglecting each other’s point of view. It also means that you do something active to improve your lives, rather than necessarily putting up with things or feeling resentful and helpless. Briefly it consists of(*Pin up SODAS poster and briefly go through headings*).

We would encourage you very strongly to go home, and this evening have a go at jointly trying to solve something that you’ve identified today as a difficult issue. To help this, write down now the “problem” area, while it’s still fresh in your minds.

(Hand out problem-solving work sheet)

Coffee break

5*Video 2 : Post natal depression.

“As we said before, a number of people get depressed in the weeks and months following the birth of a baby. It can be very successfully treated, but too often people, including health professionals, are poor at noticing that someone is depressed. So we hope this video will explain how to recognise signs of depression and how to go about getting help.”

Show video.

***Exercise:** *Group share reactions to video.*

Ask participants how they would recognise if they/their partner/ friend was depressed. How would they get help.

Ask group to describe the symptoms of P.N.D. and Baby Blues. Flip chart it.

***Preventing P.N.D.**

“We realise that it’s likely that some people will now be wondering whether they or their partner will experience P.N.D. That’s a normal concern; if we’d been talking about having triplets or Caesarean deliveries it’s likely that you would be wondering what that would mean for you and whether it might happen. There is no simple way of predicting who will and who won’t develop P.N.D. What we do know something about, is how to reduce the risks of developing it ; that’s mentioned in the leaflet about P.N.D. You’ll see that it mentions many of the things this course covers ; not surprising , since reducing the strains and stresses reduces the risks of becoming depressed. So, to underline a few things that help prevent getting depressed:

(Poster)

- being realistic about what’s ahead so you don’t get a total shock or have unrealistic expectations of your partner
- getting some “ work experience” in advance e.g. spending time with people who have babies and talking to them about what it’s like in very practical terms.
- trying to keep the number of changes in your life to a minimum e.g. avoid moving home and job, or starting major projects just when you’re expecting a baby.
- getting the practical help and emotional support you need , (especially if you are the sort of person who finds it hard to receive help)
- being aware of problems you are experiencing and taking steps to deal with them
- taking care of yourself physically (food, rest,) and emotionally (value yourself, treat yourself, talk to yourself in a caring and encouraging way)
- talking with someone about how you are feeling, especially the “negative” feelings.

N.B. these things apply to partners as well as to mothers -to -be.

“So there are some steps we can take to reduce the likelihood of depression , but the other thing is to seek help quickly if you need it. Early intervention is helpful, because it reduces the amount of distress you all, including the baby, feel, and it prevents extra problems developing for the family.”

***Exercise:** “What might stop someone getting help quickly ?”

Ask group to brain storm. Include : fear of losing child if unable to cope /feeling aggressive. Fear of stigma. Fear of being locked up in the Towers/Carlton Hayes. Loss of self esteem to admit “not coping”. Thinking these feelings are normal and have to be accepted. Thinking it will just “go away” on its own. Not wanting to upset partner by going behind her back etc.

(If appropriate or requested provide information about what treatment might include i.e. G.P.might prescribe non addictive medication, maybe C.M.H.T. referral, maybe a talking therapy, maybe practical help and support e.g. Homestart, help with the baby. Stress that, whilst of course professionals are concerned for the welfare of the baby, every effort is made to support the family in keeping the baby at home. They know that feeling unable to cope, feeling disinterested, or feeling negative towards the baby can all be part of P.N.D. It does NOT mean they will take the baby away any more than it means that she is a “bad” mother. Only in very exceptional circumstances and in discussion with the mother, might a temporary separation be suggested. Should the mother need a spell in hospital, then the baby can go too, and be looked after some of the time in the specially designed children’s nursery here at L.G.H.)

6*Summarize session.

“We’ve had a quick look at the sort of things you may experience in the first few months after having the baby, and we’ve talked about the benefits of trying to solve problems together. We’ve talked about baby blues and the difference between that and P.N.D .We’ve looked at how to get help if someone needs it. “
“If you are left with a lot of anxieties after today’s discussion, talk with us about it.”

7* Feedback and self help exercises.

****Invite feedback***

****Organise self help exercises..***

1. to jointly try and problem solve something that you identified today and wrote down earlier . Use the worksheet to help you through the stages.
2. Discuss with your partner what was helpful/ interesting/unhelpful about his meeting.
Write down things that will be useful to remember for the future? (*Hand out form for doing this on.*)

**** Distribute and collect/complete post session forms. N.B. separate ones for partners.***

****Complete leadres post session forms.***

Session 3.

Life with a new baby.

1* Welcome and rationale.

2* Agenda. (Poster)

3* Video: Bringing the baby home.

***Play video.**

***Discussion of video.**

*** Sources of strain in early weeks.**

**** Exercise: in same "role" groups: "Discuss what you expect may be sources of strain /conflict / worry in those early weeks"***

Feedback to whole group.

****Exercise: with own partner: "Talk about what applied to you and discuss how you might be able to help each other".***

4* Problem-solving. (Poster)

5* Video: Post natal depression.

***Show video**

*** Discussion of video and clarify PND and baby blues.**

*** Preventing P.N.D. (Poster)**

***What might stop you getting help?**

****Exercise: "What might stop someone getting help quickly?"***

6* Summary.

7* Feedback and self help exercises

***Feed back**

***Self help exercises.**

*1. Jointly try and problem solve something that you identified today as a likely problem, (and wrote down earlier). Use the worksheet to help you through the stages.

*2. Discuss with your partner what was helpful/ interesting/unhelpful about his meeting. Write down things that will be useful to remember for the future?

***Post session forms.**

Checklist Session 3.

Life with a new baby.

Please tick the box as the items are covered.

1. Welcome and rationale.....
2. Agenda.....
3. Video: Bringing the baby home.(20 mins).....
Discussion of video.(5 mins).....
Sources of strain in early weeks. (Separate Groups exercise)(10 mins)....
(Partner exercise).(5 mins).....
4. Problem-solving.(5 mins).....
5. Video: Post natal depression..(20 mins).....
Discussion of video& clarify PND and baby blues(10 mins).....
Preventing P.N.D(10 mins).....
What might stop you getting help? (Exercise).(5 mins).....
6. Summary.....
7. Feedback and self help exercises.(5-10 mins)
Feed back.....
Self help exercises.....
Post session foms (yours, womens' and partners).....

S. O. D. A. S.

Stop

Options

Decide

Act

Self praise and evaluate

PROBLEM SOLVING WORKSHEET

Stop

Identify a “problem” you are currently facing:

What exactly is the difficulty?

Options

Brain storm possible options.

Decide

Decide which seems best to follow through.

Action

Plan how and when you will do it (break it down into small steps)

Self praise Plan how you will tell if it has worked and how you will praise yourself for your efforts

Preventing Post Natal Depression.

- * Be Realistic (about yourself,
your partner,
the baby)
- * get “work experience” if possible.
- * avoid too many changes and upheavals.
- * get support and help (practical and emotionally).
- * be aware of difficulties and problem solve.
- * take care of yourself (physically and emotionally).
- * talk about your feelings with someone you can trust.

N.B. These points apply to partners just as much as mothers - to - be.

Three Things I want to remember from the Course

1]	
2]	
3]	

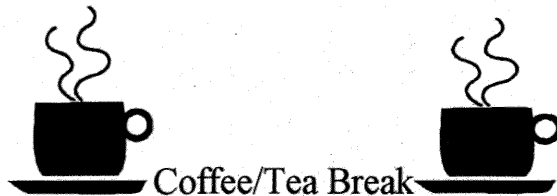
Agenda : Session 4

Social Support

Feedback and review of self help exercises

Social Support

Our support networks now
(and improving them by problem solving)



Obstacles to getting support

Feedback and self help exercises

Session 4

Social Support.

Goals:

1. for participants to understand the different aspects of support and their importance in relation to motherhood.
2. for participants to examine their own support networks, identifying strengths, gaps and problem areas.
3. for participants to explore obstacles to obtaining support (thoughts and behaviours).
4. for participants to problem solve a support issue.

Materials:

Flip chart and pens.

Posters: Agenda 4
Types of support
SODAS model (from session 2)

Handouts:

- Types of support
- Recording sheets for “asking for help”
“turning down help”
- “Beliefs about help” questionnaire.

Post session forms.

Main emphasis of session:

Social support (main emphasis)

Problem solving (less emphasis)

Thoughts and beliefs (less emphasis)

Checklist : Session 4.

Social support.

Please tick the boxes as the items are covered

(Allow about 60 mins to end of problem solving exercise)

1. Welcome back and agenda.....
2. Feedback and review of self help exercises.....
3. Social support
 - Importance.....
 - Types of support (Poster).....
 - Own support networks (Exercise).....
 - Identify areas for change (Exercise).....
 - Problem solve an example (Exercise and poster).....

(Allow 45 mins from here to end of session)

- Obstacles: Introduction.....
- “What does asking for help mean to me?” (Exercise)
- Beliefs about help (Exercise).....
- Support defeating and support enhancing patterns. (Exercise).....

4. Feedback and self help exercises.

- Feedback.....
- Self help exercises.....
- Post session forms.....

1* Welcome back and agenda.

2* Feedback:

Feed back from last 2 sessions and 2 sets of self help exercises

Very briefly remind participants of the content of last 2 sessions: any feedback? what was helpful?

Briefly remind participants of the self help exercises: what did they discover? what did they achieve? if they had problems doing it do they need to talk about that or do they understand the problem?

3*Social support.

*** Importance of support and individual differences.**

Remind people of the importance of support in easing and preventing stress .

Particularly true in the early months of life with a baby (c.f. last session) .Each person will need support of some kind at various times, but we differ in the types of support we need, the amount, and from whom. It's not simply a matter of numbers and getting lots of support: a supportive network is one that you experience as being helpful , and that depends on a host of things including being clear about asking for help, choosing the right people , valuing what they do, and most importantly, dealing with interpersonal issues that come up. Social support isn't a thing, it's a series of interpersonal processes.

***Types of support.**

Use "types of support" poster and invite examples of the sorts of support they will need in relation to motherhood.

***Our own support networks.**

***Exercise:** " Lets look at our own support networks."

Give each woman a large sheet of paper and pen; divide sheet into 4 quadrants. "Be completely honest with yourself, and fill in whoever comes to mind in response to these

questions. If you can think of more than one person , put them all down. Where you have a gap, put in a question mark. This sheet is just for you, we wont ask you to show it"

Practical

Who will you ask to :

clean up/ make you a cuppa
lend you
drive you to the hospital?
look after the baby for a few hours?
come round immediately
buy you sanitary towels /cream for piles

Advice/info

Who will you ask for advice:

when the baby keeps on crying
when the baby has a rash/spots
about buying some baby equipment
about trying something new/risky with baby
about returning to work/childcare
about your partner's requests for sex/avoidance

Companionship

Who will be also having a baby at the same time as you?

Who will walk round the park with you ?

Who will spend a wet afternoon with you?

Who will you compare weight gains with?

Who will you share the joys with

Emotional support.

Who will you look to for:

encouragement
understanding
someone to cry with
sharing your doubts and fears
reassurance
sharing your anger/resentment
helping you see the funny side

Invite Ss to look at their sheets. What do they notice?

e.g. How many people in their network? Mainly friends/family/professionals ?

Where are the gaps ? In which areas?

Where is there plenty of support?

Who gets a lot of mentions?(risks of relying too much on one person)

***Identify areas for change/development.**

***Exercise:** *Ask Ss to look at their sheets and identify areas that they feel are fine and areas they would like to change/develop.*

*** Problem solve an example:**

**Exercise: "Let's look together at an area someone would like to change: this might involve how to develop part of a network, how to maintain or start up a new area, or it might be about how to manage a problematic relationship so that it is more supportive. Would anyone like to share their example so that we can see if we can help you think of ways of improving things? Any volunteers?"*

Work through an example involving the group as much as possible in the process. Refer to SODAS poster.

If time, encourage others to relate this to their own experiences or solve another person's problem.

Remind the participants that support networks are the responsibility of both partners in the relationship. The fact that their significant other has not been invited to this session, does not mean that all the responsibility and work is hers.

***Obstacles to asking for / receiving support.**

"We all have barriers (thoughts, memories, beliefs about ourselves and others) that get in the way of seeking and receiving help. And it may be that we are unwittingly depriving ourselves of some help because of these things. We're going to look at the attitudes we hold and the ways we behave, to see if there are ways we can identify that may improve our support networks.

Of course one of the reasons we may not take up offers of help is that it can then lead to us feeling under pressure and stress to fit in with, or pay back, those who have helped us. We'll look at ways of dealing with this in session 5."

**Exercise: "First of all, let's look at what asking for help and receiving help mean for each of us?" "What is the self talk we use about asking for help?"*

Flip chart comments including:

Threat to our self esteem e.g it implies weakness, inadequacy, dependence.

Risk of being rejected, criticized, humiliated, misunderstood.

Fear of being controlled, ignored, walked over.

Risk of discovering that someone will help you/does care.

No one will want to help me ; I don't deserve it.

“These thoughts can be very powerful in preventing us getting the help we need and preventing others from being more involved with us/showing they care. As with our thoughts and beliefs about motherhood and change, it might be important to look afresh at these beliefs and challenge ones that seem unhelpful to you now. They may well have developed as a way of protecting yourself, and so, understandably, you may be fearful of thinking about things differently.

But you may be able to find other ways of “protecting” yourself now, e.g. by positive self talk, reframing what “strength” is.”

(It's important that women don't feel blamed for being how they are: check out their perceptions if you are concerned)

***Beliefs about help.**

Explain that general beliefs about asking for help can get in the way. Give some examples from the questionnaire, or appropriate self disclosure.

“Beliefs about help can mean that we “rubbish” the help we are offered e.g. one common self defeating pattern that cuts us off from care, is the belief that the only type of help worth having is that which is spontaneously offered, that we don't have to ask for. This attitude is bound to bring us disappointment and bitterness since people are not mind readers, and anyway whose responsibility is it to organize the support?

Another one is that only total, unconditional help, entirely on our own terms, is of value, and that anything less is no good and amounts to abandonment. This attitude also

generates, disappointment, a sense of not being cared for, resentment, and ultimately cynicism, since no one can live up to those standards for long.

Part of being able to receive support is being able to tolerate the times when someone misjudges what we need, lets us down, or only helps in so far as it suits them.

Feelings may also get in the way of asking for help, especially embarrassment, guilt and shame. One way of approaching this is to think how you would feel if the roles were reversed."

** Exercise: "Beliefs about help" questionnaire (If you are seriously out of time, refer to it and mention it as something they might like to do at home.) "Let's complete a short questionnaire that helps you identify your own attitudes towards help." Discuss what they discover through completing it.*

***Support defeating and support enhancing patterns.**

"Let's now look at the things we may do and say to others that could either increase the chances of getting the support we want, or reduce the chances."

**Exercise: Brainstorm "What makes you want to help someone again?"*

e.g. if they value / appreciate your efforts even if they don't take your advice.

if it then makes it easier for you to ask for help in return :the "care debt"

feeling good about being of help

enjoying doing it

Brainstorm "What makes you not want to help someone again?"

e.g. not being appreciated

being overused

being taken for granted

being stressed/too busy yourself

*having your offers repeatedly rejected, rubbished, devalued, criticized.
being expected too much of*

“We’ve identified some patterns . Think how they apply to you.”

4* Feedback and self help exercises:

****Invite feedback and questions.....***

**** Organise self help exercises.***

1. Practice asking for help at least once a day , starting with very simple requests e.g.
“can you tell me the time?”, building up to things you find more difficult. Record it on sheet provided. (Explain the rationale for this i.e. that most women find it hard to ask for help , (or to deal with the feelings when it is not offered /refused), and yet they are bound to need extra help in the months ahead. So here’s a chance to improve your skills/get used to asking .)
2. Notice how often you turn down offers of help. Record it on the sheet provided.(Explain the rationale i.e. to discover if you are the sort of person who tends to automatically turn down help. If you are , then you can think about what’s stopping you receiving it.)
3. Complete the questionnaire “ Beliefs about help” if not already done.

****Distribute and collect/ complete post session feedback forms.***

****Complete course leaders’ forms.***

Session 4: Cribsheet.

1* Welcome back and agenda. (Poster)

2* Feedback and review of self help exercises (2 sessions)

3* Social support

***Importance**

***Types of support (Poster)**

***Own support networks**

****Exercise: "Our own support networks. Write down the answers to the following questions, putting a ? if you don't know".***

Practical

Who will you ask to :

clean up/ make you a cuppa
lend you
drive you to the hospital?
look after the baby for a few hours?
come round immediately
buy you sanitary towels /cream for piles

Advice/info

Who will you ask for advice:

when the baby keeps on crying
when the baby has a rash/spots
about buying some baby equipment
about trying something new/risky with baby
about returning to work/childcare
about your partner's request for sex/avoidance

Companionship

Who will be also having a baby at the same time as you?
Who will walk round the park with you ?
Who will spend a wet afternoon with you?

Emotional support

Who will you look to for:
encouragement
understanding
someone to cry with

Who will you compare weight gains with?

Who will you share the joys with?

sharing your doubts and fears ,

reassurance

sharing your anger/resentment

helping you see the funny side

***Identify areas for change**

**Exercise: "Write down an area you would like to change"*

***Problem solve an example**

**Exercise: "Let's problem solve an area you've identified today that you would like to change."*

***Obstacles**

***Introduction.**

***What does asking for help/receiving help mean to me?"**

*** Exercise: "Self talk about asking for and receiving help".**

***Beliefs about help.**

***Exercise: "Beliefs about help"**

***Support defeating and support enhancing patterns.**

***Exercise:** *"What makes you want to help someone again?"*

"What makes you NOT want to help someone

again?"

4* Feedback and self help exercises

***Feedback**

***Self help exercises**

1. Practice asking for help at least once a day, starting with very simple requests e.g. "can you tell me the time?", building up to things you find more difficult. Record it on sheet provided.(Explain rationale)
2. Notice how often you turn down offers of help. Record it on the sheet provided.(Explain rationale)
3. Complete the questionnaire "Beliefs about help?" if not already done.

***Post session forms.**

SPECIAL NOTE

**THIS ITEM IS BOUND IN SUCH A
MANNER AND WHILE EVERY
EFFORT HAS BEEN MADE TO
REPRODUCE THE CENTRES, FORCE
WOULD RESULT IN DAMAGE**

Beliefs about Help

Here are some statements about views people have about help. Go through each statement and tick whether you agree or disagree.

	Agree	Disagree
If you depend on others for help they usually let you down	<input type="checkbox"/>	<input type="checkbox"/>
When someone offers help, 9 times out of 10 they don't really mean it	<input type="checkbox"/>	<input type="checkbox"/>
If people stood on their own feet we would all be better off	<input type="checkbox"/>	<input type="checkbox"/>
I usually keep my troubles to myself - I don't like to worry my family	<input type="checkbox"/>	<input type="checkbox"/>
When someone really loves you they know what you need without being told	<input type="checkbox"/>	<input type="checkbox"/>
If you ask for help it can make people think less of you	<input type="checkbox"/>	<input type="checkbox"/>
I like being the kind of person others lean on	<input type="checkbox"/>	<input type="checkbox"/>
I hate the thought of someone feeling sorry for me	<input type="checkbox"/>	<input type="checkbox"/>
It's embarrassing to show someone else you need help	<input type="checkbox"/>	<input type="checkbox"/>
I prefer to keep away from other people when I feel low	<input type="checkbox"/>	<input type="checkbox"/>

If you agree with three or more of these statements, then it may be these views make it harder for you to receive help or ask for help. You might want to consider trying to alter or change some of these beliefs/ attitudes using the techniques we talked about in Session 1.

Record Sheet: Turning down help

Write down offers of help that you turned down

MON	
TUES	
WED	
THURS	
FRI	
SAT	
SUN	

Record Sheet: Asking for help

Write down the requests for help you made

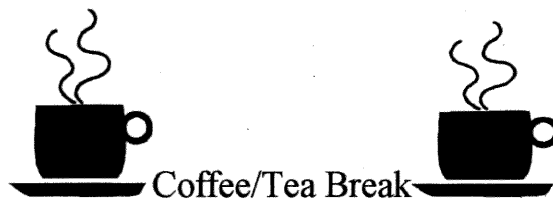
MON	
TUES	
WED	
THURS	
FRI	
SAT	
SUN	

Agenda : Session 5

Putting changes into action

Feedback and review of self help exercises

Improving our support networks
What skills do we need?



Self praise

Evaluation and setbacks

Feedback and self help exercises

Session 5

Putting changes into action.

Goals:

1. for the participants to do further work on mobilizing social support networks, using the problem solving model.
2. for the participants to identify skill deficits and practice them e.g. communication skills, assertiveness skills.
3. for the participants to understand the importance of self praise and to practice examples of it.

Materials:

Flip chart and pens.

Posters: Agenda 5

SODAS model (from session 2)

Handouts : Assertiveness

Self praise worksheet

Recording sheet

Post session forms.

Main emphases of session:

Problem solving

Social support (including skills)

Checklist: Session 5.

Putting changes into action.

Please tick the box as each item is covered

(Allow an hour for 1-3, allocating up to 30 minutes of that for identifying and practicing skills) .

1. Welcome back and agenda.....

2. Feedback and review of self help exercises.....

3. Improving support networks:

Introduction (Poster).....

Options (Exercise).....

Identify skills deficits (Exercise).....

Practice skills. (Exercise).....

(Allow 45 minutes from here to the end: at least 25 minutes of that on section 4)

☐

4. Self praise and evaluation:

Self praise (Exercise).....

Evaluation (and setbacks).....

5. Next week.....

6. Feedback and self help exercises:

Feedback.....

Self help exercises.....

Post session forms.....

1* Welcome back and agenda.

2*Feedback and review of self help exercises:

What did they discover? What was interesting about last week's session? Anything troubling? (If they did the questionnaire at home, were they surprised /bothered by what they discovered?)

3* Improving support networks:

***Introduction and review:**

- ***Introduction:** "Last week we were looking mainly at our social support networks, trying to identify and clarify any "problem" areas, and focussing mainly on what goes on inside our heads. This week we would suggest that we look further at the options we have to change/improve our networks, and the communication skills we need to do this. We also need to think about how we tell if our efforts are working."
- ***Review:** "Let's remind ourselves of the model we were using for coping with difficulties."

Show SODAS poster: go over briefly the option generation, decision making, action stages.

***Options:**

"Let's practice some option generation, because often when you are under pressure, it's hard to think of options." (People who are depressed tend to be poor at generating a range of options .)

***Exercise:** "Last week you all identified areas in your social networks that you would like to alter." Ask someone to share theirs as an example for the class to work with? (if no offers , make up one that's relevant).

Invite the group to option generate i.e.brainstorm possible solutions (remind them that this is uncensored ideas).

"How do we decide which option to try?" (i.e. what would be the consequences of each?. the likelihood of success? the amount of effort it would take?) Try to highlight examples of options discounted because of not having the skills for doing it .

***Skills:**

"We often choose a 2nd best options because we think we dont have the skills to do what we'd really like to do e.g. (use a group example if you can) or we may do without help rather than work out a way of asking for it clearly, and saying " no" to an offer of something you dont want. So this is another obstacle that gets in the way of doing what's best for us. We'd suggest we focus on these communication skills today".

***Exercise:** *"Let's try and list the sorts of communication skills that we feel we dont have, or are unconfident or uncomfortable about using."*

Invite the group to make list of difficulties.Try to group them in terms of issues e.g. making a request, beginning a conversation, declining an offer or shaping up an offer, standing firm , getting to know someone, ending a conversation , stalling, saying "NO" etc. Ask women to decide which of the list items would be most helpful for them to work on here today. (It may be that the whole group could work on one theme, or sub-groups/pairs on themes they've chosen . If the women are focussing mainly on cognitive aspects, e.g. "what will he think of me if I say" remind them about challenging thoughts and positive self talk (as we talked about in session 1)and suggest doing a behavioural test now to see what reaction others do have i.e. do a role play. The aim here is to have behavioural practice with other people in a safe setting).

***Exercise:** *Invite the women to brainstorm how they might respond to the identified problems. Try to include option generation with the emphasis on "just try saying things*

in different ways and see what it feels like,” getting feedback about what it sounds like, swapping roles to imagine what it would be like to be on the receiving end etc.

At the end of the exercise invite women to find a way of not forgetting what they've just learned e.g. get a clear mental image of themselves saying to whoever it is, or writing down what they want to say, or reminding themselves what it felt like to be asked , or 2 ways to open a conversation/ keep a conversation going..

IF time and appropriate, you may want to include something explicitly on assertiveness.

4*Self praise and evaluation:

***Self praise:**

Introduce the importance of self praise, particularly when we've done something that was difficult. "It's important in the short term for keeping you going, and in the long term for building up your self esteem. But we are often pretty poor at doing this. Instead we may look to others for their praise/ approval, and may find ourselves doing/ saying things we don't want to, just to get that approval. (give example from your own life or something a participant has mentioned). How much better if we can "praise ourselves" i.e. give ourselves the pat on the back, the hug, the smile, the acknowledgement that we've just tried hard even if there seemed little result. After all, why is somebody else's encouragement / approval so much better than ours?"

"Self praise is also important when you are struggling to keep going with something that's boring and repetitive, especially if others do not appreciate your efforts. Many daily tasks of being a mother can fall into this category, so learning to value what you've done is essential to your own self esteem. As we talked about before, mothering is often not very highly valued by society, and there's a danger that we begin to undervalue the job of mothering too. Arguably it is the most important job in a society, and yet at times we may find this hard to remember. How can we remind ourselves both about our own value

,self worth and achievements, and also valuing the job of being a mother (for which you are only paid for a few weeks if at all!)”

***Exercise :** *Brain storm as a group self praise/self affirmation statements. “What can we say to ourselves to value who we are and what we are doing?”*

Invite participants to fill in some self praise statements on their record sheet as the group generates them . This will make the self help exercise easier.

***Evaluation:**

Introduce the evaluation stage and dealing with setbacks.

“Going back to the model , after praising your efforts ,you will need to evaluate whether your action worked, and if not, dealing with the setback.. It can be very disappointing if your efforts had little impact, and you may feel like giving up at that point. But it’s really quite unusual for things to come exactly right first time; you need to look at ways to improve the chances of success, altering bits, trying again etc. Many of us have the tendency to only notice the bits that didn’t work; so make sure you look for both the bits that went just fine and acknowledge those, as much as the bits that didn’t work. Otherwise it’s all too easy to give up and fall into a state of helplessness or inverted triumph (“I told you so, nothing will change ”/ “ I’m no good /it’s not worth it”). Sometimes it’s helpful to get somebody else’s view as well on how something went, since we may find it hard to be objective if we are dissatisfied.”

5*Next week:

Remind them that next week is the last meeting of the course,(apart from the reunion), so need to think about that, and also anything that they would like to spend some time on next week, and maybe exchange phone numbers if they want to. Collect suggestions of any topics they want to mention.

6* Feedback and self help exercises:

***Feedback**

***Arrange self help exercises:**

1. Practice an aspect of a skill that you find difficult, and record how it went (evaluate) . (Provide worksheet) Explain the rationale: you're unlikely to learn a new skill without practicing it.
2. Write down and practice using self praise statements. (Provide worksheet).
Explain rationale: as above, but also we are having to overlearn new self statements in order to override older, unhelpful ones. Also, the more we rehearse and use positive self statements, the stronger the impact it will have on our self esteem and morale.

***Distribute and collect post session feedback forms.**

*** Complete course leaders' forms.**

Session 5: Crib sheet.

1* Welcome back and agenda. (Poster)

2* Feedback and review of self help exercises.

3* Improving support networks:

***Introduction (Poster)**

***Options**

****Exercise: Option generation and decision making.***

***Identify skills deficits**

****Exercise: "Let's list the sorts of communication skills we feel we don't have or are unconfident about using".***

***Practice skills.**

****Exercise: "Let's practice how we might say things."***

****Exercise: "Work out a way of remembering what you've just learned."***

4* Self praise and evaluation:

***Self praise**

***Exercise: Brain storm possible self praise/ self affirmation statements. Write them down on the worksheet.**

***Evaluation (and setbacks)**

5* Next week.

Any "Loose ends" they would like to discuss/ go over next week?

6* Feedback and self help exercises.

***Feedback**

***Self help exercises**

1. Practice an aspect of a skill that you find difficult, and record how it went (evaluate) . (Provide worksheet)
2. Write down and practice using self praise statements. (Provide worksheet).

***Post session forms.**

***Complete course leaders' forms.**

Record Sheet:Skills Practice**Skills to practice:****Record times when you practised a skill and how it went**

Skill practiced	How did it go?
1]	
2]	
3]	
4]	

Record Sheet: Self-praise

Write self-praise statements you can use and record how often you use them

Self-praise Statement	Put a tick each time you use it						
1]							
2]							
3]							
4]							
5]							
6]							

Agenda : Session 6

Coming to an end and facing a new beginning

Feedback and review of self help exercises

Loss or absence of support

Loose Ends



Course Review

Planning ahead

Feedback and self help exercises

Session 6

Coming to an end and facing a new beginning.

Goals:

1. for participants to address issues to do with loss or absence of support, both with the ending of the group and from important people in their lives (partners/mothers).How to internalise support.
2. for participants to review the main points of the course ,to evaluate their experience, and practice giving each other feedback.
3. for participants to have time for “loose ends”, thinking ahead and planning goals.

Materials:

Flip chart and pens

Any agenda items mentioned last week

Posters: Agenda 6

Handouts: Coping with loss / absence of support.

The positive power of anger.

Worksheet: 3 things to remember.

My short term goal.

Post session forms.

EPDS

Envelope containing course review forms and research measures.

Main emphases of session:

Emphasis on social support and thoughts.

Some on sharing.

Checklist: Session 6.

Coming to an end and facing a new beginning.

Please tick off each item as it is covered.

1. Welcome back and agenda.....
2. Feedback and review of self help exercises.

Allow about 20 to 30 mins on section3.

3. Dealing with loss/absence of social support
 Emotional aspects (Exercise).....
 (Optional exercise).....
 Practical aspects (Exercise).....
4. "Loose Ends"
- ?4A (optional) Sharing information.....

Allow at least 20 mins to review the course and plan ahead.(5 and 6)

5. Review course.(Exercise).....
 (Exercise)
6. Planning ahead. (Exercise).....
7. Reunion.....
8. Feedback and self help exercises.(Allow extra time for completing EPDS)
 Feedback.....
 Self help exercises.....
 Post session forms
- (also EPDS, and forms to take home).....

1* Welcome back and agenda.

2* Feedback and review of self help exercises.

3* Dealing with loss or absence of support.

Introduction:

“Up to now we’ve been talking about ways to increase and develop support networks. We need to also think about times when these are absent and we can’t do anything to change this, or when we suddenly lose the support we are used to having. This is relevant to what’s happening here in this group ; namely this support is coming to an end in its current form.”

There are 2 aspects to dealing with the lack/loss of support: emotional and practical.

***Emotional aspects.**

“Often it’s hard to be effective at dealing with the practical side if we’re feeling full of strong emotions. Let’s try and understand a bit more about this”

***Exercise:** “1. Who do you most mind being let down by? 2. What contributes to the strength of feeling? 3. How do you react to feeling let down and how does that effect how you cope?”

Write up on flip chart under the headings.

- 1) e.g. those closest to you; people who you thought you could always rely on; people who have said they would do “anything” for you; someone suddenly not being there in a way they usually are; people you’ve helped a lot
- 2) e.g. feeling that they “ought to help” either because of their relationship to you or because of all the things you’ve done for them . Cognitions to do with how you explain their lack of support can make you feel much worse e.g. “it means he doesn’t

love me / I don't deserve help / I'll never cope on my own / that's the last straw / if he won't even do this he won't do anything at all to help etc.

- 3) e.g. sulk, feel mardy, seeth silently, retaliate, cry, explode, feel abandoned and helpless. This could effect how you cope in terms of : can't think clearly / don't want to see alternative sources of help / make snap decisions / i.e. can't problem solve effectively.

“ So , our feelings are likely to be particularly strong if we feel let down by someone we feel “ought” to be supportive e.g. partner/mother. And yet these are the very people with whom we have had the most complicated relationships, and who are themselves going through major adjustments now, with the arrival of a new baby. Old conflicts, old grudges and resentments may all resurface to get in the way of them offering the support you are seeking and may make their “failings” seem particularly hurtful. And what's especially hard is that this is all happening just at the time when you are most looking for support and when you may be feeling emotionally vulnerable.

Some people just do not have the capacity or skills to be emotionally supportive or to offer advice in an unbiased way , however much we think they “ought” to. It's the other side of “mothers ought to be all caring, nurturing, loving, self sacrificing, putting their children first” : part of us is usually still hoping that our mothers will fit this image, and of course they fall far short of it now as they may have done in our childhoods. We need to start saying goodbye to the fantasy of the perfect mother (or partner.) Waiting for the perfect mother/ partner is wasted energy and only reminds you of her shortcomings. It's more helpful to accept that they have failings , and to acknowledge what they are good at , and what they aren't good at . Also it may be that someone else would actually be better at providing the sort of support you want. e.g. is your reluctant and short tempered partner the best person to support you at the birth? Is your mother the best person to ask for guidance on how to deal with the baby? Would someone else be better for you?”

“Dealing with the feelings in a constructive way is also important; acknowledging your feelings and just how much you mind, finding an outlet for the feelings so that they don’t add further fuel to the fire are crucial. Expressing anger safely, letting the tears fall, acknowledging your anxiety, will all help in processing the feelings and freeing you up to then solve the problem. Finding ways to express anger is particularly important: there is some truth in the old saying that depression is anger turned inwards on yourself. (see article)”

“Be careful that you are not saying things to yourself that are making the situation worse. How can you talk to yourself in a way that acknowledges your feelings but doesn’t lead you down a self defeating path? It’s like dealing with setbacks that we talked about last week i.e. not letting one disappointment throw you completely.”

***Optional Exercise :** “How might we talk to ourselves helpfully in this example?”*

Imagine that your partner has refused to do something that you see as important, and is much less than you regularly do for him.

What could you say to yourself helpfully?”

e.g. I’m furious that he’s not helping , (and that’s partly because I always help him out and I don’t ask much of him)and it’s making me think that maybe I shouldn’t have asked. *But* I have every right to ask, and I did well in asking clearly, and I do mind that he’s said no. I feel let down. But it doesn’t necessarily mean that he never cares about me or that you can’t rely on anyone. And it’s my choice how much I help him; I’m free to offer or not. So I’ll either talk with him again about it, when I feel less steamed up, or ask someone else to help.

***Practical aspects.**

** Exercise: Invite the group to come up with practical ways of coping with loss or absence of support. This may also relate to losing this group.*

- If coping on your own , mention **empowering self talk**, e.g. “remind yourself of times you’ve struggled through things before, and that you may not enjoy it but you will

survive.e.g.Put on Gloria Gaynor's song "I'll survive" very loud. Recall memories of when you were well supported and the good feelings and confidence you had then. This **internalised support** can help sustain you through empty times."(Mention their personal files as something they can refer to, and moments in this group.)

- If your way of coping is to find someone else for support, " it will be easier if you already have in your mind , if not on paper,a list of people you can call on for different sorts of help. Remember the list you made in Session 4 . Also if you've already done things for them and have asked if they'd mind helping in an emergency,that makes it easier for you to ask them when you need to, and for them to be prepared to help."

4* Loose ends:

Invite questions or topics that people would like to talk about. It may be going over a topic or new areas. If the group can answer their own questions and lead their own discussion, so much the better.

Optional 4A : Sharing information.

Depending on how the group decided to share information about local resources/books/tips etc this may be a time for group sharing.

5*Reviewing the course:

"We're coming to the end : let's review where we've been and then think about where we're going .

From our perspective we've tried to put across several ideas that can be helpful in reducing strain and stress and preventing post natal depression : having information , being able to openly share concerns, using support networks, thinking in ways that help us rather than hinder us, and problem solving as a way of coping with life's "problems".

Personally, I've(include genuine personal comments about what you've enjoyed / learned/ will remember)"

***Exercise:** *“What will you take away from the group? Write down 3 things that you don’t want to forget. It might be something someone said, something you discovered about yourself, something you want to watch out for, a good feeling (provide worksheet)*

We’re not going to ask you to share these so be very honest with yourself.”

***Exercise:** *“An important way of internalising support is to remember moments that were supportive that you can recall later.*

Let’s share with each something of our experience of the course: moments that you have found helpful or enjoyed, tough times, ways in which other people here have helped you. This is an opportunity to practice giving feedback and receiving compliments, and discovering ways in which we have helped each other.” (Encourage women to give feedback to each other . If they are talking about the course content, say we will review that at the end of the session :this is a time for being a bit more personal).

6*Planning ahead.

***Exercise:** *“Let’s look ahead? What short term goal do you have?”(Encourage small simple consolidation goals. Esteem enhancing, support mobilising, empowering self talk etc)*

Write up on flip chart: one goal for each person and shape it if very unrealistic.

If they can’t think of a goal, offer some options: the idea is to reinforce the notion of driving our lives, not just passively ticking off the minutes, even in the run up to the birth. Use the worksheet.

7*Reunion:

Remind women of the date, and ask for ideas of how they’d like to use the time. Stress that it’s particularly important to come if things don’t feel too good. Encourage the participants to exchange phone numbers today, with people they want to keep in touch with. *(If time, discuss what might stop them coming to the reunion)*

8* Feedback and self help exercises:

***Feedback:**

***Self help exercises:**

1. Go through the course file and make obvious and accessible things that are important to you. Remind yourself of them i.e. Let the course and the group go on helping you.
2. Write down the day and time of the reunion.

***Distribute and collect EPDS**

***Distribute and collect post session questionnaires.**

***Distribute envelope containing course evaluation forms and research measures.**

Explain the forms and the importance of their completing them in terms of us needing feedback about the usefulness or otherwise of this course. Ask them to complete the forms at home in the next few days and return them in the prepaid envelope.

***Complete course leaders' forms.**

***Adieu and good luck.**

1* Welcome back and agenda. (Poster and “loose ends”)

2* Feedback and review of self help exercises.

3* Dealing with loss/absence of social support

***Emotional aspects**

**Exercise:*” 1. *Who do you most mind being let down by?* 2. *What contributes to the strength of feeling?* 3. *How do you react to feeling let down and how does that effect how you cope?”*

Optional exercise: “How might we talk to ourselves helpfully in this example?

Imagine that your partner has refused to do something that you see as important, and is much less than you regularly do for him.

What could you say to yourself helpfully?”

***Practical aspects**

**Exercise: Invite the group to come up with practical ways of coping with loss or absence of support. This may also relate to losing this group.*

4* “Loose Ends”

?4A (optional) Sharing information.

5.* Review course

**Exercise: “What will you take away from the course? Write down 3 things to remember”.*

**Exercise: Share moments that were supportive/ helpful.*

6* Planning ahead.

**Exercise: “Let’s look ahead. What short term goal do you have?”*

7* Reunion.

8.* Feedback and home work .

***Feedback**

***Self help exercises**

1. Go through the course file and make accessible things that are important to you. Remind yourself of them i.e. Let the course and the group go on helping you.
2. Write down the day and time of the reunion

***Post session forms**

1. Distribute and collect back EPDS
2. Distribute and collect back post session forms.
3. Hand out the envelope containing course review forms and research measures.
4. Complete course leaders forms.

*** Adieu and good luck.**

Agenda : Reunion

How are we? Where to now?

How are we?

Achievements and current difficulties

Taking care of ourselves

Goodbye

1* Welcome back and congratulations.

2* Agenda. (Poster and additions)

3* How are we?.....and really?

***Achievements and current difficulties**

***Taking care of ourselves**

4* Goodbyes and keeping in touch.

5* Post session forms.

Checklist: Reunion.

How are we? Where to now?

Please tick each box as the item is covered.

1. Welcome back and congratulations.....
2. Agenda.....
3. How are we?.....and really?
 Achievements and current difficulties.....
 Taking care of ourselves.....
4. Goodbyes and keeping in touch.....
5. Post session forms.....

Reunion.

How are we? Where to now?

Goals:

- for participants to honestly share how they feel and how they are coping. For them to identify achievements and current difficulties (practical and emotional).
- for participants to review how well they are taking care of themselves, and to identify ways of improving this.
- for everyone to say goodbye and arrange ways of staying in touch if they want to.

Materials:

- Flip chart and pens
- Feedback forms
- Agenda poster
- Polaroid camera

Main emphases:

Sharing

Some attention to social support and problem solving.

(This meeting may well start slowly as people arrive late with babies, and want to greet each other. Use this time to have a few words with each woman. You may have to work quite hard to keep people on track today.)

1*Welcome back and congratulations. Hello to all the babies

“Have you congratulated yourselves for giving birth, surviving hospital, getting back home, beginning to get settled etc AND on getting here today? How about some self praise?”

2*Agenda.*(include anything mentioned in last session also in addition to what's below)*

Agenda poster.

Invite additions to agenda from women and include on poster. Point out that today we'll need to adapt to having the babies here; invite them to feed, change, walk around etc as needed. Acknowledge that they may just feel like chatting and swapping experiences today, but suggest we try and do some other things as well, since they have all made the effort to come. This is a chance to consolidate what they learnt on the course and to refresh themselves.

3*How are we?.....and really?

Invite sharing, particularly of difficult areas.

***Achievements and current difficulties.**

Invite everyone to share one thing they feel good about/an achievement.

Invite everyone to share something that's difficult, either emotional or practical. (Offer prompts if necessary e.g. difficulties with relatives, partner, feeling unconfident, depressed, frustrated). N.B it would be abnormal not to have any difficulties at this stage.

***Taking care of ourselves.**

Invite discussion about how people are taking care of themselves and what gets in the way of it. Reinforce positive thoughts/actions and offer reminders about the importance of social support, positive self talk, self praise, treats, etc.

Who do they get support from? Any surprises? What do they need to do to take better care of themselves. N.B. it's quite possible that someone in the group is feeling depressed, and may need to think about getting some professional help.

4*Goodbyes and keeping in touch. *(the amount of emphasis on goodbyes will depend on how much was done in session 6 and where the group is at. Use your judgement, but if in doubt, overdo the goodbye)*

Acknowledge the ending of this group and its significance. e.g "we've been on a journey together, and now we're all getting off the boat and going our separate ways. Some will be saying goodbye for ever, others will want to meet up again, others will want to have phone numbers/ addresses in case they want to make contact. Think about who you want to keep in touch with and be sure to make that possible before you disappear today. It's been a very personal journey and we've shared a lot together; think now if there are things that you want to say to the group as a whole or to a particular person. (You may wish to model /say things here e.g. appreciation of peoples' openness and courage, humour, struggle, hardwork, tolerance of your own fumbles, sadness about or happiness about..... I will miss.... I have enjoyed..... thank you for..... i.e. whatever is relevant and acknowledges real aspects of the group's journey)

Remind women that they will be contacted by the research worker in number of weeks time, and that whilst you do not expect to meet them again, they know where you are should the need arise.

Group photo.

5*Distribute and collect/complete post session feedback forms.

Session
 Date/...../.....
 Your number.....

Post session feedback : Participants' form

Thinking about today's meeting, how much did the following happen?
 Not everything will have happened today ; we are interested in your impressions.

	A great deal	A lot	Quite a lot	A little	Not at all
• Being given information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Talking about social support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Thinking about childhood experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Looking at thoughts, beliefs, predictions etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Exploring hidden wishes and fears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Problem solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Openly sharing feelings and concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Overall, how helpful was today's meeting?

Very helpful	Helpful	A bit helpful	Neither helpful nor unhelpful	A bit unhelpful	Unhelpful	Very Unhelpful
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What did you find most helpful? _____

What did you find least helpful? _____

Any other comments ? _____

Session

Date/...../.....

Your number.....

Post session feedback : Leaders' form

Thinking about today's meeting, how much did the following happen?

Not everything will have happened today ; we are interested in your impressions.

	A great deal	A lot	Quite a lot	A little	Not at all
• Being given information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Talking about social support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Thinking about childhood experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Looking at thoughts, beliefs, predictions etc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Exploring hidden wishes and fears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Problem solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Openly sharing feelings and concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Overall, how helpful was today's meeting?

Very helpful	Helpful	A bit helpful	Neither helpful nor unhelpful	A bit unhelpful	Unhelpful	Very Unhelpful
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What did you find most helpful? _____

What did you find least helpful? _____

Any other comments ? _____
