Therapist guide

Project ECHO

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Introduction

"It's just a lot to handle—being pregnant, feeling so stressed, not knowing what's going on with my body or my emotions."

Depression is both a common and debilitating disorder. Listed by the World Health Organization as the 4th leading cause of disability worldwide, it is projected to be the 2nd leading cause by 2020. Affecting up to twice as many women as men, an estimated 15-25% of women will experience depression during the course of their lives (Kessler et al. 1998). Depression strikes women with greatest frequency during the childbearing years, impacting both the woman and her child (Goodman & Gotlib, 1999). However, few women suffering from perinatal depression receive mental health treatment (Marcus et al. 2003) leaving them and their children vulnerable to the negative impact of depression. Prenatal care settings provide an optimal opportunity for engagement and intervention since they are highly accessed by women with untreated depression. However, effective depression management strategies have been understudied in these settings. Indeed, treatment of perinatal depression presents special challenges since many

women choose not to take anti-depressant medications and many have physical, practical, and psychological barriers such as energy and mobility limitations and stigma concerns. These factors likely contribute to the fact that evidenced-based, face-to-face psychotherapies such as Cognitive Behavioral Therapy (CBT) are under-accessed by this population. There is subsequently a strong need to improve the acceptability of and adherence to evidenced based psychotherapy for pregnant and post-partum women suffering from depression.

Overview of Perinatal Depression

Depression impacts emotional, physiological and psychological functioning. Interpersonal discord, marital conflict, and poor parent-child relationships have been consistently linked to problems associated with depression (Zuckerman et al. 1990; Rudolph et al. 2000; Bradbury et al. 1996). Depression's intrafamilial impact is perhaps most evident in the relationship between mother and the developing fetus or newborn infant. Depression in the antenatal period is correlated with shorter length of gestation and lower birth weight (Hoffman & Hatch, 2000), and results in greater cortisol reactivity in the newborn, an effect that persists into early childhood, placing the child at risk for developing depression (Lundy et al. 1999). Depressed mothers breastfeed less often, and stop breastfeeding earlier in infancy (Field, Hernandez-Reif, & Feijo, 2002). Maternal depression also has a continuing influence on

the infant's cognitive and emotional development. In depressed mothers, the mother-child relationship is characterized by insecure attachment (Nagata et al. 2003). Depressed mothers have greater difficulty accurately perceiving their infant's emotional expressions (Broth, Goodman, Hall, Raynor, 2004), and perceive their children as more difficult and themselves as having poorer competence as a parent (Teti & Gelfand, 1991). Behaviorally, infants of depressed mothers are more likely to be withdrawn, less excitable, and less oriented than those of non-depressed mothers (Lundy et al. 1999). They are also more likely to exhibit eating or sleeping difficulties, and are less likely to engage with visual or vocal stimuli (Righetti-Veltema et al. 2002).

Given the well-documented extent and risks of maternal depression, it is critical to treat mothers suffering from depression. Persons appropriately treated for depression have shorter periods of illness, are less likely to relapse, and have longer periods of inter-depression wellness than those who are not treated, or who are under-treated (Frank et al. 1990, Segal, Williams, & Teasdale, 2002). Existing treatments for depression, including antidepressant medications and cognitive-behavioral therapy, have been found to be efficacious in treating up to 70% of affected individuals, with persons with fewer episodes of depression responding better to treatment (Dobson, 1998). Initial results also suggest that effective treatment for maternal depression has a positive impact on both mother and child functioning. Efficacious treatments have been shown to improve or restore overall maternal functioning, prevent the negative infant neurobehavioral outcomes associated with maternal depression, and improve mother-infant relations immediately post-partum and at 18-month and

5-year follow-up (Logsdon et al. 2003; Moses-Kolko, & Roth, 2004; Murray, et al. 2003; Verduyn et al. 2003). Thus, providing effective treatment for women has the potential to positively impact familial outcomes in both the mother and child. As a result, it is imperative to reach women in need.

Symptoms of Depression

♀ **Differences Between Postpartum Mood Changes:**

Baby Blues:

Postpartum Depression:

Postpartum Psychosis:

Overview of Enhancing Care and Health Outcomes (ECHO) Study

Despite the existence of efficacious treatments, few women with perinatal depression receive treatment (Marcus et al., 2003). In a recent study of perinatal depression, only 13.8% of 689 women who screened at risk for depression reported that they received any type of mental health treatment within the previous 6-months, suggesting that the vast majority of these women do not receive any type of treatment for their depression (Marcus, Flynn, Blow, & Barry, 2004). These rates were notably lower than national rates of depression treatment, which range between 30-50%, suggesting that this very high risk group is accessing treatment at a lower rate than the general population (Young et al. 2001). Pregnant and post-partum women who do connect with mental health services receive

treatments well below depression treatment guidelines (Marcus, Flynn, 2005;). In addition, few women who seek care do so in specialty settings. The majority of women receive mental health treatment in general medical settings, such as obstetrics (Katon et al. 2003). Women cite general medical settings as preferable treatment settings. Obstetrics is less associated with psychiatric care, thereby reducing the stigma of seeking care (Scholle et al. 2003). Women also report that they would be willing, and prefer, to receive one-on-one counseling in a general medical setting (Van Voorhees et al. 2003). Thus, obstetrics offer an excellent venue in which to treat mental health disorders.

Poor treatment engagement and adherence in the perinatal period is a complex phenomena involving barriers across many levels, including both system (e.g. health care policy, clinician training and reimbursement, health care system resources), and individual level barriers (e.g.physical limitations, childcare issues, stigma, treatment and venue preferences). The ECHO project is a step towards developing a pragmatic approach to address individual level factors that may impede treatment engagement in pregnant and post-partum women suffering from depression. (later include more rationale, methods and findings).

Pre-Treatment: Factors and Considerations

Before beginning treatment, there are some techniques that will be important to consider to make this treatment successful.

Tailoring Pre-Treatment Interventions to Clinic Settings

Many women report that they prefer having mental health treatment available in a primary care setting. This can be useful in the following ways:

Convenient. Women are attending prenatal care appointments often during pregnancy, and may find that scheduling mental health sessions at the same time is easy and comfortable.

Continuous. Women may benefit from having their OB providers know that they are experiencing stress in pregnancy that contributes to their mood. Providing mental health care in the OB clinic allows this to happen.

Less stigmatizing. For many women, depressive symptoms in pregnancy are perceived as shameful or embarrassing. Receiving care in the OB clinic may reduce this stigma associated with mental health care. Phrasing the care as being preventative or "stress-relieving" may also help with reducing treatment fears.

Affirming. Connecting mental health treatment with OB visits allows women to consider mental health treatment part of their self-care as well as beneficial for their baby. This connection can reduce the guilt women have around getting mental health care and potentially increase treatment engagement and adherence.

Working within the Prenatal Care Setting

Confidentiality. Women in this study will have the opportunity to allow their obstetric provider to see weekly mood scores and to see that they are in treatment. Some women may choose to keep this information completely confidential. It is your job to honor the client's wishes by maintaining strict confidentiality about all aspects of treatment that she is not comfortable sharing with other providers. (maybe put examples of appropriate/inappropriate confidentiality disclosure?)

Professionalism. It is important that you are able to "blend in" as part of the system of care the client is used to at her clinic. Be sure to adhere to clinic policies which may include dress codes, regulations regarding hair, fingernails, or footwear, etc.

Prenatal Knowledge. Because you are providing care within the OB clinic and are providing "specialty" care to perinatal women, it is important that you become familiar with basic information regarding pregnancy, birth, complications, and infant parenting practices. Some of this information is provided within this manual. However, additional resources for finding information are included in Appendix X.

Engaging Clients in Treatment

After talking with women about what kind of care would be helpful to them, we found that women would like to talk with someone who is open, nonjudgmental, and able to listen to what they need. When talking to women at the initial sessions, remember:

- Provide a warm, supportive, and nonjudgmental atmosphere.

- "Check in" with women throughout the initial session to see if the treatment approach seems to meet their needs.

- Don't assume that each client is 100% enthusiastic about beginning this treatment. Ambivalence is normal and should be expected and explored in a decision like this one.

In this treatment approach, it is very important to be aware of many reasons treatment may be difficult to complete for women. The role of the therapist involves being in tune with the many demands placed on women in the perinatal period, so that women feel valued and understood by you as a therapist. Here are a few ways you can decrease barriers to treatment, whether you are meeting women at the clinic, at home, or by telephone:

- Call ahead same-day or night before to remind and check in about session.

- Double-check directions to house/access to clinic room .

- Ask her if she had any trouble keeping the appointment. For clinic visits, "Did you have any difficulties getting here today?" If so, problem-solve with woman to remove any barriers. For home visits, "Is this still a good time?" when planning for following week. After first session in home, check in with woman about how she feels about home visits for future sessions.

- Be sure to start and end on time.

Treatment Overview

You will be administering an adapted form of cognitive-behavioral therapy, commonly referred to as CBT. This manual will provide the basic tools you will need to conduct each session. The treatment is designed to be completed in 8 sessions. The treatment is divided into modules, or topics. You will work with your client to choose two modules that best fit with the client's presenting problems. Treatment sessions may look something like this:

Sessions 1-2	Individualized assessment and overview of CBT model
Sessions 3-4	Application of first module
Sessions 5-6	Application of second module
Sessions 7-8	Review and preparation for ending treatment

Modules included in this manual:

Module 1: Assessment
Module 2: Behavioral Activation
Module 3: Enhancing Social Support
Module 4: Cognitive Restructuring
Optional Module 5: Pre and Post Labor/Delivery

Additional Resources:

(List final interventions and resources here)

Logistical Aspects of the Treatment

Arranging the Sessions:

The key to this treatment is to provide the most flexible service possible. This means that we are willing, whenever possible, to meet women in their homes, at the OB clinic, over the telephone, or any combination of these three, although for the purposes of this trial, face-to-face delivery is preferred.

Initial three sessions: Session may be either coordinated with the woman's next regularly scheduled midwifery appointment, or can be arranged as a home visit. It is preferable to have face-to-face meetings with the woman.

Subsequent sessions: During the initial session, provide all three options of delivery and elicit from the client which would be preferable for her. Take some time to address any barriers that may come up.

Length of Sessions: Each session typically takes around 45 minutes to complete. However, based on the client's needs and circumstances, customize the length of the session. It may last 30 minutes on the phone because the baby keeps crying, or it may last an hour because she has an hour before her OB appointment.

Special Issues for Telephone, Prenatal Care Health Clinic, and Home Sessions

Telephone Delivery

- Provide tips to decrease distraction (schedule therapy time as any other appointment, find a private space, turn off t.v., etc.)
- Discuss any risk issues (screen for domestic violence)
- Discuss how to handle call waiting, how many times the therapist should call if there is no answer, and other potential barriers.

Prenatal Office

- Ensure that a private space is available for each session time.
- Be very clear with providers and with your client about confidentiality and what information is made available to nurses, OB's, etc.
- Highlight that treatment is not billed to insurance despite using clinic space.

Home

- Ensure privacy as much as possible by working with the woman to find a private area in the home if others are present.
- Be friendly and open with other family members when greeting them at the home or by phone, while remembering to maintain confidentiality regarding anything you've discussed in treatment sessions.
- Work out a plan with your client about how to handle family members and friends interrupting the session. For example, if the partner walks in during the session, ask the participant, "Should we keep going?" Follow your client's lead.
    - It is important to discuss these types of events before they occur. Problem solve

with the client to address how to handle interruptions before they happen.

- Do not assume that your client will be home before or following delivery. Be conscientious of the multitude of women's experiences around pregnancy, motherhood, and parenting. Home may be especially inconvenient if she works out of the home for a majority of her day.
- If she has children in the home, prepare for them by bringing toys and child-friendly items such as crayons and coloring books. Maximize the first 20 minutes of the session and allow the client to take frequent breaks to interact with the children, give snacks, and take care of herself the children.

♀ When children are present during the session, pay particular attention to the needs of the client and the children. Also, refrain from disciplining the children or inserting personal advice about how to the handle the children.

Using "on the spot" happenings as fuel for discussion is often a powerful technique, especially if the child(ren) and parenting are a source of stress.

Detection and handling of risk issues

Throughout your interactions with the client, be alert to potential risk issues: suicide risk, domestic violence, and child abuse. Included in appendix X are current risk protocols. When attending a session, carry essential resource numbers (such as Psychiatric Emergency Services and Child Protective Services), as well as the outlined protocol.

Guidance for Every Session:

Module 1 focuses on the first session(s) and is focused on "Assessment" in order for the therapist to obtain an in-depth picture of the experiences the client faces. Included in this module are guidelines for principles and stylistic suggestions for the therapist to use throughout ***every session***.

Discussing Depression Screen

Based on research and clinical experiences, specific features are consistent throughout every session and module. At the beginning of each session, the therapist will ask the client to complete a depression screen (the Edinburgh Postnatal Depression Screen, EPDS) in order to track the client's mood. Questions to ask when reviewing the EPDS include specific questions around answers (especially those that have risen significantly) and exploring contributions to the increase or decrease in her score **("What has caused this score to go up this week?" "What has caused this score to go down this week?").**

Use the graph in the appendix to track her weekly EPDS score. Often, clients forget how badly they were feeling, so showing them the changes in their scores can be helpful in recognizing the changes they've gone through.

Agenda Setting

The client and therapist will set the agenda of every session together at the start of the session. This process is based on collaboration. Ask the client for her input— "What do you want to accomplish in this session?"—and also provide your input—such as, "I want to come back to some points we were discussing last time and talk more about them."

Homework

Homework serves multiple purposes: experimentation and learning outside of the therapy session, reinforcement of material covered in session, insight into the client's life and particular mood changes, and focus for the sessions. Homework (or out of session assignments) has been shown to be effective in helping the client reduce her depressive symptoms.

Addressing Barriers

Throughout the therapy, the therapist should keep an open dialogue with the client going around possible and existing barriers (both physical and mental) that prevent the client from attending therapy and completing assignments. For example, if the client feels ashamed for being depressed and has a hard time attending therapy, it is important to discuss these feelings with her. If she is having trouble completing the homework because of her literacy level, then create with her a more workable homework assignment.

Global Principles for Each session

- Affirmation of strengths
- Normalization
- Respect for autonomy
- Asking permission
- Eliciting reactions following each intervention

Session Checklist

- ☐ EPDS score, graphs, elicitation of mood change influences.
- ☐ Elicitation / negotiation of session agenda
- ☐ Homework / inter-session work review
- ☐ Maintain focus on agenda (modules)
- ☐ Assessment of resource needs / problem solving
- ☐ Reminder of session number
- ☐ Inter-session work / homework plan
- ☐ Schedule subsequent session and assess potential barriers

How to Incorporate Multiple Modules:

Why to incorporate and not be totally manualized:

One of the main goals of this treatment is to provide individualized, flexible care while still using the main principles described in the manual. This is not an easy, straightforward task, and may require quick thinking at times. However, the benefit is that women can receive therapy that feels relevant to their particular situation every single week. As a therapist, you have the freedom

to follow the client's lead if a particular module seems to warrant additional emphasis, or if another module doesn't seem to be meeting the client's needs.

When to use multiple modules within a session or to overlap info:

At times, you may find that it is appropriate to integrate more than one "module" in the same session. This may be most appropriate when:

1. An issue addressed in a previous session has re-emerged or could use a reminder (e.g., I remember when we talked before you were saying that when you sit on the couch, it really impacts your mood, and when you get out of the house a while you start to feel better).
2. An issue seems to be highly connected to both topics (e.g., a client's thoughts about being a burden on her family are contributing to her difficulties communicating her needs effectively).
3. You are transitioning from one module to another (e.g., client is moving from behavioral activation to cognitive restructuring within the same session, or you are preparing for cognitive work in the next session).

Integration across modules: referring back to previous modules, introducing future modules.

It is natural to transition between modules, and often pointing this out to the client makes the treatment feel more fluid.

- **Referring back to assessment module to determine next module:** "You've really made a big commitment to getting reconnected with the activities you used to find meaningful. To what extent do you think that being more active has had an impact on your thoughts? What about on your relationships? While you continue to keep track of your daily activities, which of those other areas do you think it makes the most sense for us to focus on next?"

- **Referring forward to an upcoming module**: "It seems like that thought that you're a disappointment to your family has really made it difficult for you to communicate with them the way you'd like to. Right now, we've been focusing on the communication and how you'd like that to go, but next week would it be okay if we came back to this thought and focus on how it impacts your mood?"

Examples:

1. **Assessment:** Referring back to the original assessment to discuss progress made toward goals in each domain, and how they affect other areas of functioning. For example, it may be useful to have a participant reflect on how progress in interpersonal communication has impacted her daily activity level.

2. **Behavioral Activation:** In discussing behavioral activation, a woman may find that referring back to the initial assessment chart is

helpful in understanding barriers to becoming engaged in her life's meaningful activities.

3. **Cognitive Restructuring:** Monitoring events, thoughts, action, and mood links can be especially insightful into social support issues and deciding the target area.

4. **Social Support:** Thought patterns are often closely tied to social support interactions. She may feel that she is unlovable, that she has to have an intimate partner, that no one wants to be around her because she is pregnant or because she just had a baby, and other thoughts around her life changes. It may be helpful to work on these issues together.

When is this therapy not appropriate?

Guidance on dual-diagnosis

How to Use This Manual

Therapist Script:

Text on the side is sample therapist script—examples of how to apply the described interventions and styles. See the expanded case examples at the end of every module for more examples.

This manual is meant to be used to provide individualized and flexible care and treatment. Each module contains background information, guiding principles, and several possible interventions. It is not necessary to use every intervention or to follow the specified order of interventions in a module. Maintain the individualized focus throughout the therapy, which means sessions will follow the pace and needs. of the client. Use the interventions included in each module with discretion and pay attention to the needs of the client.

Quotes from interviews with pregnant and postpartum women are included to provide examples of how women sometimes feel.

This manual contains an appendix with questions, concerns, and potential issues for the treatment overall as well as detailed questions for each module. Weekly supervision can also help to answer additional questions.

Each module provides perinatal information. Some important points are spotlighted in boxes such as these listed to the right.

♀ Perinatal information that has been a major theme in the interviews and sessions with pregnant and postpartum women.

Module

1

Individualized Assessment

"Everything has been overwhelming. My job has me working too much, my doctor tells me to lessen my stress, I'm worried about the financial expenses of a new baby, my car has been acting up, I've been fighting with my family, I stay up worrying about all this and then I feel tired all the time."

The initial and early interactions with the client are critical in that they will play a key role in whether she chooses to continue with the interventions. Research has shown that women have a strong need to feel that their perspectives and concerns are heard, acknowledged, and normalized, that is, a client does not want to be made to feel that she is "crazy" or "abnormal". We also found that women have very different ways of thinking about their symptoms, causes, and solutions, and have different intervention needs. It is important that all of this be elicited in a respectful, normalizing way.

Another important goal in Phase I is psychoeducation about interventions that are effective and available. Many women do not believe that treatment is necessary unless their symptoms are very severe (e.g. feeling suicidal or unable to function), and may not feel that they necessarily have "depression". Therefore, it is important to inform women that the best time to address some of their difficulties is before they get too

severe, and that there are ways of doing that that have been found to be very effective. **Also, use language that is consistent with her language; if she calls her depression "stress", then call her depression "stress."**

Background Information

Beginning with an assessment is a logical first step. This step should not be rushed and can last from one to three sessions. While you may feel that you are not accomplishing much by taking such time, this is an essential piece of the treatment, specifically because it helps builds trust and a therapeutic relationship. Likewise, by truly listening and learning about the client's needs, you are providing the individualized care that she needs.

Selection of Module

Clearly, this module is to be used in the initial sessions of every treatment. The information gathered in this assessment will be used to identify following modules that will be most relevant to a woman's particular needs.

Key Principles

- Collaborative, Client centered
- Skill and Strength based
- Flexible, tailored, customized
- Informed by research

Goals and Strategies for Module

The purpose of the assessment is to:

1. Build collaborative relationship through Active listening, Affirming, and Respecting Client Autonomy
2. Assess various domains of contributors to depression
3. Normalize client's experiences
4. Introduce CBT model and elicit client reactions
5. Identify and build strengths, communicate optimism for improvement
6. Identify and individualize early modules based on assessment
7. Assess ancillary needs

Overview of Goals, Interventions and Handouts

Therapist Script:

"I am very interested in working with you to figure out what would be most helpful. In order to do that, I would like to ask you a bit more about what has been going on and how you have been doing. Would that be okay?"

(insert table similar to other modules here)

NOTE: Not all techniques will be used for all clients, and some women may need more time than others to complete each goal. Remember to keep treatment individualized and flexible.

1. Building a Collaboration

The basic goal here is to communicate that you and the client are working together on addressing her needs. Our research has found women prefer a style characterized by the following:

Open Ended Questions - are a way of eliciting more information in a way that pulls requires more elaboration than a "yes / no" answer.

Reflections - are a way of trying to capture the essence and meaning of what the client has communicated by responding with a statement that is essentially a guess or hypothesis (in the form of a statement), as in this example:

P: I stopped going to therapy because they just didn't seem interested in what was wrong with me.

T: You didn't feel heard by them.

P: Yes, they were giving me a bunch of technical stuff, and they weren't listening to me.

T: You weren't sure how what they were telling you fit your experience and how it would be helpful to you. Makes sense that you decided not to go back.

Active listening - is a style of remaining highly engaged with what that person is saying and some of what is meant by the communication. Reflections, open ended questions, and frequent summaries of what you have heard the client say are the best way to both understand and to communicate understanding of what is being communicated. Research has shown that use of reflection and questions result in high ratings on scores of therapist empathy by objective raters.

Therapist Script:

"You're very invested in being the best mother you can."

"You've done so much on your own."

"You are an important support for your family."

Affirmations - are specific kinds of reflections that reflect the client's strengths. They should be used whenever you pick up on a specific strength of the woman, and should be particularly directed at her efficacy, specifically in domains determined to be most important to her.

Respect for Autonomy - It is important to keep in mind and to explicitly communicate that what each women does is up to her. This should specifically be done in conjunction with provision of psychoeducation, information, and options. Remember that one of the key features of this treatment approach is flexibility and provision of options. Every woman

is different in terms of what will be most helpful to her and what she is ready, willing and able to do at this time.

Summaries - are a way of checking out with the client what you have heard her say to that point, and can be used to allow her to correct any misunderstanding on your part. Be sure to qualify your summary at the beginning with a statement that lets the woman know you it is open to alteration. Then, invite her to add or correct any information at the end of the summary in order to check out how accurately it fits with her view of the situation.

For example:

T: Let me see if I have it so far….please let me know if there is anything that I have misunderstood. You haven't been feeling well physically, and although you're happy about the pregnancy, you've been feeling more alone now that your boyfriend is working more hours. Sometimes you worry so much about how things will be when the baby comes that it's hard for you to get through the day. At the same time, you've been working hard, reading, going to doctor visits. You are clearly invested in trying to take the best care of yourself and be the best mom you can. Did I miss anything?

2. Assess various domains of contributors to distress

Introduction to you and the treatment- Begin the first session with a brief introduction. Women may have different expectations about what they will be doing in this session, so it is important to clarify your role and your approach:

T: We know that while pregnancy can be very exciting and positive, it also brings stresses and often unexpected changes in

mood. Talking about these stresses and thinking about ways to deal with them can be one of the most important steps in preparing for your baby's arrival. Would it be okay if we spent some time today reflecting on all the changes that might be going on in your life right now, including some things that may be stressful or difficult?

Therapist Script:

I'd like to hear what this pregnancy has been like for you.

What has your mood been like lately?

What are your thoughts on why you've been feeling this way?

What's it like for you to talk with me about this?

Open-ended introduction and listening- Although later in the assessment process you will have specific questions and ask for detailed information about a woman's symptoms, at the beginning of the session it is important to ask just a few broad questions to allow her to feel comfortable with you and talk about her experiences.

♀ In our research, we found that many women want reassurance that they aren't the only one feeling this way during pregnancy. Also, women may find it relieving to hear that their reactions are normal and not a sign that they are a bad or crazy mother.

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3. Normalize women's experiences

Use client's language: Don't assume a woman suffers from depression, or would label her problems as depression. Do listen carefully to how she identifies her symptoms, and use the language she uses to describe herself. Most importantly, take every opportunity to normalize women's changing feelings during pregnancy and reassure them that these meetings are designed to help with both large and small stresses in pregnancy.

Therapist: *What has this pregnancy been like for you?*

Client*: I've just been so stressed….it's been hard. Not like I thought it'd be.*

T: *Actually, many women feel as though pregnancy is a more stressful time than they expected it to be. It's understandable that you would feel overwhelmed with so many changes going on. What changes have you noticed in yourself when you're under stress?*

Therapist Guidance:

Using the word "stress" is often much less threatening and stigmatizing than "depression." Other potential words to use include: "mood", "mood ups and downs", "down", "sad/blue", "overwhelmed", and any other key words that the client uses to describe her feelings.

P: *"It's just when you say depression, it's like, oh, God, I'm not depressed. I'm just stressed out. But that is a form of depression, so maybe if they did say it like that, it kind of be a little more appealing to the women."*

♀ **Women may be receiving messages that their mood changes are simply related to their hormonal changes, and these messages may minimize their feelings. Normalization in conjunction with validation, active listening, and compassion is very important in helping your client feel heard and not as though she is "over-reacting."**

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4. Introduce CBT model and elicit client reactions

After the client has a chance to talk about her experiences and you are familiar with the language she uses to talk about her

symptoms, it is useful to introduce the "big picture" of cognitive-behavioral therapy (CBT). This is a brief introduction….more details about each part of the model and the therapy will be explained later. (refer therapist to the more extended version of the CBT background info).

Summarize and ask permission to introduce CBT approach- An important step in providing collaborative care is to check in with the client before providing new information.

Provide gentle psychoeducation about depression and rates of depression in pregnancy.

"A number of women experience the kinds of problems you're having as well."

"Pregnancy has a lot of challenges that can cause struggles with mood, but those struggles can look different. For some women it means feeling down. Other women might feel really irritable, or worried."

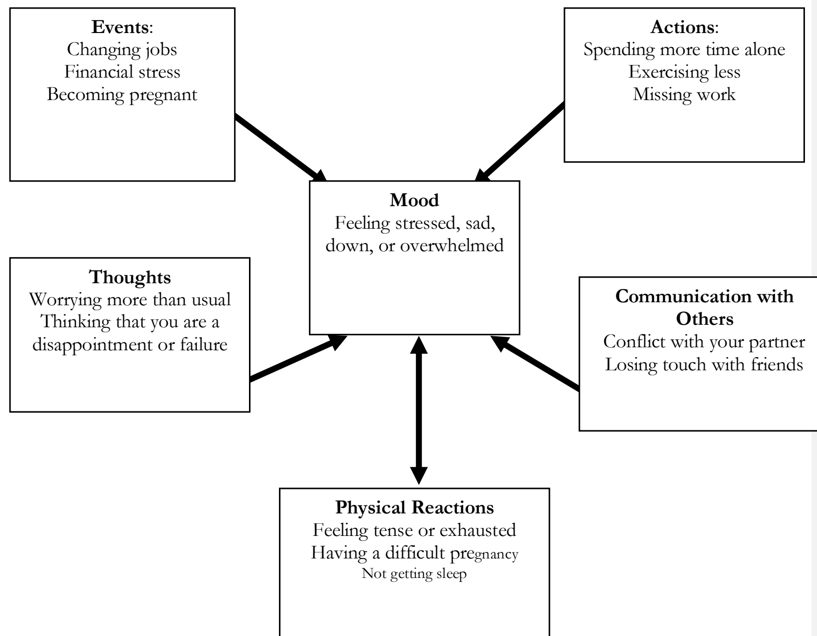
"It is common for women to have additional stress during pregnancy and after giving birth."

Ask to introduce CBT approach.

T: From our conversation so far, it seems as though you've really noticed a change in your mood during this pregnancy. I have some information here that has been a useful way to understand stress and mood changes for other women. Would it be okay if I shared this information with you now?

Provide Summary of CBT approach-The basic framework for this approach is that thoughts, behavior, mood and physical health are inter-related, and decades of research show that each affects each other in maintaining depression. It is likely that work on 1-2 areas may have a positive impact on the other

areas, which will positively impact their symptoms. Our research has shown that women in the perinatal period report problems along the following 5 domains:



Provide a brief, basic overview of each section of this model. The key features are:

- Each of these "pieces" can impact our mood. For example, spending less time with friends after having a baby can lead to feelings of loneliness.

- Each piece is connected to each other. For example, thinking "my friends will think I'm boring now that I have a baby" or "I look too fat to go out" may impact how lonely you feel [thoughts impact mood], but it also

may decrease the likelihood of you calling your friends to go out [thoughts impact communication with others].

- This model can help us "make sense" of our symptoms. Most of the time, we can see relationships and patterns in the way we feel, act, and think.
- Because they are all connected, we can make changes in any one place and feel the effects in other areas. Kind of like (house of cards: pull one, they all come down; windchimes: move one, they all start playing; a knotted string: can start loosening from several points and eventually straighten out)
- Each person is unique. This model will look different for each person's particular thoughts, life events, etc. Therefore, when completed by the client, the model becomes relevant to the client.

Therapist Script:

"When we change just one of these things, we can have an impact on all these pieces. Even making little positive changes can have wide ripples that help us feel better. How does that meet your expectations?"

Check in with client's reaction to the model- Before moving on to discuss your client's specific situation within the model, it is important to gauge how she is responding to this idea.

- What are your thoughts on this?
- How does this fit/not fit with how you see your current symptoms (use client's words)?

Use CBT model to complete individual assessment- At this point, the goal is to use the CBT model as a framework for understanding the client's current symptoms. Using the different "nodes" as a guide, work with the client to understand how each piece of the model is currently relating to her mood.

Events

- Tell me about what has been going on in your life recently.
- How do you see these events impacting your mood?
- What is going well for you right now?
- This might include: financial stress, changing jobs, moving, unexpected pregnancy.

Actions

- How have you been spending free time?
- Have you noticed changes in your daily activities? (things you used to do but not now; things you do now that you have not in the past)
- This might include: avoiding particular activities, engaging in solitary behaviors, etc.

Thoughts

- Do you notice "themes" in the way you find yourself thinking about yourself?
- (If client has identified a stressor in her life)…when you think about that, what kinds of things run through your mind?
- Do you find yourself thinking any particular thing that really makes you feel low, or hopeless, or angry? (examples might be, It's all my fault, I'm all alone, This will never change).

Communication with Others

- Who do you feel most supported by right now?

- Tell me about the people who are most important to you.
- What do you like about that relationship? What do you wish could be different? How has your relationship changed since you started to feel (client's words)?
- Look for: supportive relationships as well as conflictual, unsupportive, or absent relationships.

SOMETIMES IT IS HARD TO DISTINGUISH PREGNANCY FROM DEPRESSIVE SYMPTOMS. TWO STRATEGIES FOR CLARIFYING ARE:

1. **COMPARING TO OTHER PREGNANCIES IF SHE HAS HAD SEVERAL**
2. **COMPARING TO OTHER TIMES SHE WAS DEPRESSED OR STRESSED BUT NOT PREGNANT.**

Physical Reactions

- Tell me about how you've been feeling physically in this pregnancy.
- Have you noticed changes in your body during other times of stress, not during pregnancy?
- How have you been sleeping? Eating?

Below is an example of a young woman seeking treatment. Notice how the different pieces fit together….for example, her actions (avoiding friends, not asking for help) may contribute to her thoughts that she is alone and her feelings of being overwhelmed.

Situations:
Our pregnancy was unexpected, and it was a real shock to my parents.

We found out from the ultrasound that something might be wrong with the baby, but we couldn't know how bad it might be until he was born.

Thoughts
I can't stop thinking how I'm a disappointment to my parents.

I just feel like this isn't how it was supposed to go…I just feel like no one cares about me. Like I'm all alone.

Actions:
Well, I haven't gone anywhere because of the migraines and the complications.

I don't ask anyone for help because I feel like it's my fault, I should take care of it myself.

Mood
I just feel overwhelmed, like I can't do this.

It's like I'm not the same person I used to be, and I can't seem to get out of this slump.

Physical Reactions
I had migraines all through the pregnancy and afterward for about 2 weeks.

I guess when I get stressed, I eat more, and that's what happened in this pregnancy. I put on a lot more weight than they expected.

Relationships with others
My boyfriend wouldn't go to my appointments with me or talk with me about the baby's complications.

Whenever I talk to my parents about my boyfriend, they tell me I should leave him and that just makes me feel worse. So we don't talk about it.

Check in with client's reactions to this assessment.

- What has it been like for you to view your current feelings in this way?
- What connections do you see between these areas?
- Is anything standing out to you as particularly surprising, interesting, or helpful in this?
- How is this similar/different from how you view your symptoms?

5. Identify and build strengths, communicate optimism for improvement

Ways to get at strengths:

Therapist Script:

"What has worked for you? What hasn't? What have you tried?"

When you hear her strengths, affirm these qualities and refer back to them throughout the sessions.

Throughout the assessment, try to pay special attention to strengths a woman exhibits: these may be things or people that motivate her to make changes, a history of handling difficult experiences, particular insight into her symptoms, or previous periods of depression-free functioning. After the assessment, note these in your communication with her.

Useful questions for identifying strengths:

- How has she dealt with difficult situations in the past?
- Does she have any relationships that feel especially supportive?
- What does she value in her life that provides motivation for change?
- Is she engaging in any activities that seem like positive influences on her mood?
- How can past successes in another area be applied to current problems?
- What can she learn from her supportive relationships that she can use to improve other relationships?

Therapist Script:

"Since this is your first episode of depression and you are seeking treatment, you are making a huge step in lessening the effect of depression on your life."

Communicating Optimism for Improvement- Your client's depression may contribute to a feeling that the future is hopeless and these symptoms cannot change. By providing specific feedback that indicates an optimistic outcome, you are actually engaging in the first step toward changing these thoughts.

T: "From what you've told me, you have several invaluable strengths such as (x,y,z). I feel confident that working together, we can find ways of lessening these feelings of being down. We can use a variety of tools to figure out what works best for you. How do you feel about this?"

6. Identify and individualize early modules based on assessment

After communicating optimism, follow with communication about individual modules that appear to be most important for the woman's depressive symptoms. Be certain to continually check in with the client as you are giving feedback, to ensure that you are choosing a module that is based on her perceived need.

One of the most important aspects of this treatment is to provide an informed, flexible, collaborative approach. Because of this, you and your client have several options for where to "start" in the treatment. Based in CBT, this is not a one-size-fits all kind of approach. It is a set of focused techniques and strategies that can be flexibly and individually tailored to an individual given their unique difficulties and problems.

These questions may help you choose which modules to begin:

What is most troubling to the client about her current symptoms?

Which domain (thoughts, actions, etc) does she believe impacts her mood the most?

Are there any domains that seem "untouchable" or that she is not currently willing to address or change?

Does the client view any domains as being dependent on another domain for change? (e.g., does not see worry thoughts changing until she is able to secure housing).

T: Part of the reason for thinking about stresses in this way is to help us determine the best approach for improving your mood. We know that some specific strategies exist for each of these areas and that many women have felt more in control of their mood after using them. Each woman is different, and so we can decide together what would work best in your situation. I have some ideas about where we might start based on our conversation. Would it be okay if I shared that info?

Choosing a module- This can occur by discussing an area of great need, followed by a specific example of some interventions used in that module, followed by checking in with the client about how useful this will be for her.

T: *You've talked about several things that impact your mood, like not getting sleep, having conflicts with your parents, and thinking you're a disappointment to your family. It seems from what you've told me that the thoughts and the relationship conflict are really central to your mood change….how does this fit with your view of it?*

P: *I think that's right*

T: *Since these seem to be important, there are a few ways to address these in our meetings together. For example, (give example here of specific intervention). What do you think about this approach?*

PLANNING FUTURE MEETINGS:

Now that we've talked about what we would do here to help address your mood symptoms, the next step is to decide if this is something you think would be useful to you right now.

Ask Permission to Plan Future Meetings

You have just "proposed" a general treatment plan, and now it is time for the client to determine if it meets her needs. Remember that it is perfectly normal and acceptable for the client to decide not to seek treatment at this time.

It may be helpful to use a "commitment ruler" to engage the client in talk that emphasizes her commitment to treatment. For example, ask her, on a scale of 1 to 10, how committed to/interested in she is to treatment. If she says "6", ask why her response is not "0" or "1". Ask her how this fits into her goals.

7. Assess ancillary needs

Once a woman has agreed to continue with the treatment plan, check into any other pressing concerns that might get in the way of treatment. There are many reasons women might not return to treatment, and normalizing and anticipating this can be helpful in planning for the future.

T: You know, it's not uncommon after a meeting like this for someone to intend to come back, but then change their mind or have something come up between now and next week that makes it hard to get to the meeting. Can you think of what might come up in your life that would have this kind of effect?

Potential barriers:

- Conflicting responsibilities
- Transportation, childcare
- Problems with important support person
- Shame around seeking treatment
- Doesn't see how treatment will address the problem.

It is important to create a **plan together** for how to handle situations that can arise, such as if the client misses an appointment. Ask the client how she should be reached (by telephone, letter, etc) and the frequency that you should use to try to reconnect with her (for example, decide together that you can call her up to five times without hearing back). This normalizes the fact that clients sometimes disengage from treatment, as well as establishes a customized protocol for handling this type of situation.

8. Closing and Preparing for Next Session

Finalize your meeting time and place with the client. Discuss checking-in/confirming her appointment a few days in advance. Review the checklists in the appendices regarding appointment locations and logistical concerns. You may want to develop a plan for the upcoming session—for example, if the therapist is calling the client on the telephone, the proposed number of times the therapist will call will be 3 times. Discuss where the client will talk on the phone and work out details about call-waiting, distractions, and other issues. Refer to the checklists in the appendices to help with troubleshooting.

Include information about what she can expect in the upcoming sessions and stress her active role in shaping the content for discussion every week. Provide her with an idea of the structure of the sessions and remind her of the value of her input—especially if the therapy feels unhelpful or if she has any barriers come up.

T: *We're going to set an agenda together at the beginning of every session. If you have any concerns or issues that come up over the week, please include those in the agenda so that this time together is meaningful for you. If you feel like something does not feel like it is working, please let me know.*

Therapist Script:

"Sometimes it is useful to have someone else come in to be your ally. While this isn't couples therapy, you can bring in your partner if you like, or any other significant person in your life. Before this person comes in, can we talk about the expectations we have for this person?"

Inviting a supportive other to attend. Social support is important for improving treatment outcomes, and we believe it may also be important in improving treatment adherence and commitment. This serves several purposes.

1. **Improve treatment engagement.** First, if at least one other important person in the client's life knows that she is in treatment, this may help her to receive encouragement and allow her to share her treatment experiences with someone in her life.
2. **Receive normalizing feedback.** Second, having a significant other join a session may allow the client to check out beliefs and expectations of motherhood that may not be shared by others, such as, "I have to change everything about my life when this baby comes" or "I have to do it all by myself, or else I'm a failure." Often, family members may share their own imperfections in raising children, or be able to give feedback that others do not expect these things from them.
3. **Gain another's perspective on symptoms.** Third, the therapist may benefit from hearing about the client's experience with depression from another's perspective. This is rich and valuable information that can help determine the course of treatment.
4. **Provide information and elicit support.** Finally, having a significant other attend a session can allow the therapist to provide some psychoeducation about depression and elicit commitment from the significant other to provide support for the client during the pregnancy and postpartum period. In the initial assessment phase, therapists should encourage women to bring in significant person in their lives—this could

be a mother, partner, relative or friend—and share one session with them.

T: "Some women find it very helpful to invite someone who is important to them to join in one of the sessions. These sessions can help your family member feel 'on board' with your treatment and leave you feeling more supported than you did before. How would you feel about this idea? Who in your life do you think it would make most sense to invite to treatment?"

It is helpful for the therapist to clarify with the client what will and will not be discussed in the joint session. Share with her the purpose of the session, and let her know that anything she has shared individually will be kept confidential and not shared during the join session.

During the assessment, the client may indicate some interpersonal conflicts with a significant other. If planning to address any of these interpersonal conflicts within the joint session, see the social support module for further guidance on this topic. **If domestic violence and/or abuse is present, inviting the significant other is not an option.**

Example Session Structure

1. Meet client before OB appointment.
2. Discuss recent events, current mood, and behaviors/actions.
3. Plan for next session—discuss barrier of transportation and plan next session for preceding OB appointment.

Summary

Therapists should attend to the basic elements outlined in this module. These elements should be carried over into subsequent

sessions. Listen for any doubt from the client and move at her pace. Provide normalization of her distress and discomfort while also reflecting back her strengths and needs.

Case Examples:

Description of the client

Information of Assessment:

Sample dialogue

Transcribe sample session and Create one simple, “goes well” session

Insert frames with “coding” the techniques and reference information

Insert symbols by “coding” session

Module

1

Behavioral Activation

"I just feel so down. I end up staying in bed all day, which makes me feel even worse."

This module addresses the role of behavior in depression. Behavioral Activation (BA) looks at depression from the "outside-in." According to BA, behavior and mood are often linked, so one clear way to address mood distress is to address the behaviors that contribute to a negative mood. BA also proposes that it is important to look at the context in which the behavior occurs.

The theory behind BA notes that people who are depressed are often caught up in a cycle of avoidance. Avoidance is not necessarily a bad thing. We all avoid. For example, if you are tired from working too hard, it might be good to temporarily avoid starting a new, intensive work task and instead take time to recuperate. If the recuperation helps you to engage in new tasks with renewed vigor, then *in that context*, the avoidance was probably a good thing.

Often though, people avoid to get away from something stressful or negative. Avoidance can easily go awry, and this is the case in depression. Avoidance becomes problematic when it (1) shuts down opportunities/isolates, (2) causes additional problems, (3) and is long lasting. This type of avoidance leads to further depressed mood. Among

pregnant and postpartum women, physical discomfort and lifestyle changes can also contribute to being inactive or isolated.

It is important to note that avoidance does not always mean *not doing* something. Often people are very busy, but they may still be avoiding important things.

Interrupting and reversing avoidance patterns is an important step in treating perinatal depression.

Behavioral activation (BA) helps people take steps towards re-engaging in their lives in meaningful ways that will help improve their mood. In the perinatal period, this may mean trying out different strategies to help a client get her ongoing needs met, or she may need to develop ways to overcome new hurdles to support more meaningful behavior. The ultimate goal is to reduce depressive behaviors and improve healthy behaviors.

BA is a personalized approach. BA addresses the specific circumstances and functions of behavior for a particular person. It does not assume that what is unhelpful for one person is unhelpful for another. BA does not assume that all solutions work for all people. Instead, BA focuses on exploring behaviors that are helpful and unhelpful for a particular person, and what activation is needed to help that person recover from depression. Finding out what activities are meaningful for each client is an essential component of this approach.

♀ During and after pregnancy, women go through several physical changes and may struggle to find activities that they feel they can perform, especially meaningful activities.

Women who are used to being active may have a hard time with low energy levels and physical transitions. Women who are bedridden or have restricted activities may feel like their days drag along (or are longer because they are home) which can impact their mood.

BA focuses on increasing meaningful and important activities. It does not blame a client for her depression because of her behaviors. It recognizes that people do things for a reason, and that often these behaviors may have worked in the past, or in the short term, but they are not working for the individual in her current context.

Background Information

Depressed individuals have often experienced "depressive" learning environments. They learned that they would receive little reward for a great deal of effort. (e.g., putting a great deal of effort towards creating a happy family with little positive feedback). At the same time, they also learned that they could cope with punishing or stressful situations through avoidance (e.g., rumination which is excessive thinking with very little action, not discussing an important topic for fear of negative outcomes, or isolating themselves).

Commented [g1]: Not sure this needs to be included.

Therapist Script:

"Having a child (even if it is not the first one) changes so much about daily life that most women find they are doing a lot adjusting to the activities they do for fun or fulfillment. What sort of changes have you been experiencing?"

Stress during pregnancy and parenting is normal and to be expected. Becoming pregnant and being a mom may require a lot of changes in a woman's lifestyle: the way she handles new problems, asks for help from others, manages daily responsibilities, or relieves stress. Let her know that this is a common challenge during and after pregnancy. Depression during this time period can also limit the activities she is engaged in or thinks that she can do.

♀ **Pregnancy and parenthood often introduce many "unknowns" and unexpected experiences. This transition often calls for many changes in women's lives, including their behaviors, dealing with stress, and managing responsibilities.**

In the perinatal period, women may find themselves dealing with many new adjustments. Their attempts to gather support may have been less successful than they expected. In the end, they may have learned to manage the stress of their current situation through avoidance and passive behaviors. These behaviors are often discussed as coping mechanisms.

"When the kids start crying and everyone is asking so much of me, I just sit down and shut my eyes. I feel so overwhelmed."

In a behavioral activation model, it is important to pay attention to avoidance behaviors. Clients may exhibit avoidance in a number of ways, including: procrastination, trying to avoid thinking about upsetting or emotional events, suppressing feelings, avoiding new challenges or risks, withdrawal, giving up activities that they were previously good at or enjoyed, not expressing feelings to other people, and rumination. Although avoidance may be a natural reaction to a short term stressor, in depression it may have become habitual and is often reinforced by the environment (e.g., a new mother finds it "easier" to care for her child rather than take the time to request help so that she might take a nap). By avoiding new and or difficult situations, depressed individuals reduce opportunities for solutions to problem situations. Avoidance also prevents exposure to new and disconfirming information (e.g., client worries that her partner may not appreciate new parental role, although a direct conversation may reveal alternatives. For instance, the partner may not know how he/she fits in and desires to find a way to increase parenting responsibilities).

At the same time, some depressed individuals may be quite active. However, these actions may be unfulfilling or inconsistent with their personal goals. For example, the individual may be quite busy caring for the needs of others, at her own expense. She may then feel dissatisfied, unfulfilled, and upset about feeling those emotions.

It is important to work with her to explore how often she is engaging in meaningful activities, as well as how they impact her mood.

Selection of Module

"I feel like there is nothing I can do. Sometimes I dread getting out of bed and find it impossible to do anything, including little things like washing the dishes."

Choose this module when the client selects focusing on her behaviors and activities as her interest for therapy. Choose this module when she seems to be avoiding and disengaged in meaningful activities. When a client's depression is interfering in routine activities (especially daily self-care), then BA can often be a useful strategy for helping a client get back on track.

Therapist Script:

"Could we talk more about the activities you have been doing and not doing?

Tell me more about what type of activities you have been involved in.

What activities have you stopped doing? "

A useful way to determine if a mom is engaged in avoidance is to look at a simple mood-activity chart. If the mother is not engaged in many activities that contribute to better mood, it is worth exploring what kinds of things used to lead to better mood, or what activities she'd rather be doing. It is also helpful to talk about what is getting in the way of her living the way she'd like to. (E.g., "I hate being in the house all the time. I feel so cooped up. I'd prefer to get out with the kids, but I just don't.")

Behavioral activation can often bring about an immediate feeling of competence and a noticeable decrease in depressive symptoms. Therefore, it may be a good place to start the therapy process after the assessment. Likewise, it may be a useful module to obtain more information about the client, especially in regards to unhelpful thought patterns that get in the way of meaningful action or social support concerns.

Key Principles

- Actions impact moods and related thoughts. The best way to reduce avoidance behaviors is not to simply talk about them, but also to explore and try out new behaviors. This is called "experiential change."

- Clients are encouraged to distinguish between their depressed behavior and healthy behavior patterns. Clients are encouraged to find situations that increase experiences with potentially rewarding and positive activities and decrease depressive behaviors.

- Behavioral Activation encourages clients to act despite feeling poorly. Clients are encouraged to put one step in front of the other, and not to wait for motivation to act. The focus is action.

- Action should be concrete, achievable, and in line with the client's goals, which makes the action more meaningful and also builds feelings of confidence and self-efficacy.

Goals and Strategies for Module

The purpose of BA is to

(1) Determine the specific patterns of coping that have contributed to depression for that particular individual. Use a mood-activity log to get a sense of what a client is doing.

(2) Develop a plan to improve coping and enhance opportunities for positive reinforcement in individual's environment. BA is guided by what the client wants to achieve from her life, and finding the most effective ways to be successful.

The therapist should consequently keep several key questions in mind:

What is important to this client? What activities will help this client achieve a sense of purpose and improve her mood?

Is there an imbalance in her activities (E.g., is she doing a lot of routine/urgent activities, but very few activities that are important or pleasurable?)

Within the client's current context, how can I help her to do things differently so that her actions are more in line with her goals?

Overview of Goals, Interventions and Supplements

Goals	Intervention	Supplements
1. Recognize mood and behavior links	1A: Assess client's experiences	
	1B: Introduce and explore mood tracking	**Mood Tracking Log**
	1C: Introduce TRAP model	
2. Build behavioral alternatives	2A: Identify and Try out Alternative Coping Behaviors	**TRAP to TRAC**
	2B: Graded Task Assignment	
	2C: Exploration of life goals	**Life Goals Handout**
	2D: Role-playing	
	2E: Problem-solving	**Problem solving worksheet**
	2F: Acting "as if" feeling better/more confident	

NOTE: Not all techniques will be used for all clients, and some women may need more time than others to complete each goal. Remember to keep treatment individualized and flexible.

Goal 1. Recognizing the link between mood and behavior

Clients are asked to become active observers of the impact of their actions on their mood. This is accomplished both with the behavior/mood tracking form and informally through client observations of the links between actions and mood.

Intervention 1A: Assess the Client's Experiences and their links between mood and activity

Introduce the concept of mood being linked to activity. Whenever possible, make discussions concrete, and specific to the client. For example, it is often useful to talk to the client about the day they've just had and the activities they did. Sometimes, within on day many different moods and activities occur, and it can be a good opportunity to compare and contrast what the client was doing and what their mood was. Or, if the client's mood was fairly consistent throughout the day, it can be helpful to compare that day with a day where the client's mood was different.

When doing this, the purpose is not to judge her behaviors, but to explore with her which behaviors are helpful and unhelpful in regards to her mood. These questions are ideally used in conjunction with a mood/activity log.

Therapist Script:

"What has your mood been like today? What did you do today? How does that compare with yesterday? (or a day where the client felt better or worse)"

"What activities did you used to do when you were feeling less depressed/happier?"

Has being pregnant changed the kinds of activities you do? How so? What is your mood like now?"

Sample Questions to explore her experiences.

- Tell me about a day when you felt down. What was going on that day? What were you doing?
- Tell me about a day when you felt happier (or a time when you felt happier). What happened that day? What were you doing?
- What kinds of things would you like to be doing with your day?
- What activities and goals are important to you? Which of those things are you not doing much of right now? Are there any you'd like to see change?
- What kinds of things make it difficult to do the kinds of activities you'd like to be doing?
- When you weren't depressed, what sorts of activities did you use to do? (When you weren't pregnant?)
- What makes those activities difficult to do now?

This exploration may offer an opportunity to discuss the difference between depressed and healthy behaviors. It is important to normalize that depression often makes us feel less like doing things that we enjoy. It often clouds our vision in terms of what we think we can do.

a. Depressed Behavior: Actions related to their depressive symptoms such as avoiding or excessive thinking.

b. Healthy Behavior: Actions directed toward attaining personal goals or improving overall quality of life

♀ **Having a child is a huge life transition and this change needs to be normalized. It is normal for activities to change. Whereas she may have been able to do numerous tasks in one day (go to work, wash clothes, make dinner, spend time with friends, attend meetings, etc.), she may find herself unable to do very much do to lack of sleep and the responsibilities of the new baby.**

Intervention 1B: Introduce Mood Tracking

Therapist Script:

“You've provided several examples of the types of behavior you are engaged in and not engaged in. One way to examine our behavior patterns is to use the ABC model. Could we look at this model together and look closer at your experiences?”

Therapist Script:

“Recording your actions and mood helps both you and I get a good look at what your weeks are like. It also helps us find patterns and identify what is helpful and unhelpful. How do you feel about filling this out for a week? What do you see getting in the way of completing it?”

Tracking activities and mood is a critical step to identifying behavioral patterns that are sustaining and intensifying your client's depressed mood. It is important to discuss the structure and expectations associated with this exercise. A few key points are listed below.

1. Behavior tracking should be simple and specific.

2. Clients should be encouraged to record behaviors with short, straightforward phrases rather than detailed phrases e.g., asleep, feeding baby, phone call with Marie, walk, then home watched TV.

3. Clients should also record their mood and rate it on a scale of 1-10, with 1 being the least intense, and 10 being the most intense feeling associated with that mood.

4. Ideally, clients will complete a mood-activity log on an hour-to-hour basis. This allows for a rich and thorough picture of their lives. However, this may sometimes not be practical. In those circumstances other strategies should be employed. For instance, the client could track their mood and general activities for chunks of time during the day (E.g., morning, afternoon, evening, night), or they could track their mood, and when they noticed it changed, could write about what they were doing.

Time:	Day and Date:

Midnight	
Mood	
1:00	
Mood	
2:00	
Mood	

As with all the exercises in this manual, it is best to first practice the exercise prior to asking the client to complete it on their own during the week. For the mood-activity chart it is best to first ask the woman to think of a time in the past week when she felt poorly. Ask her to describe this time, with a focus on what she was doing.

Therapist: *"Can you tell me about a recent time when you felt down? Do you recall what you were doing during that time? And, if you had to rate your mood when that was happening, with 1 being the least intense and 10 the most intense, what rating would you give your mood? Do you also recall what day that was? About what time was this happening?"*

Client: *"I called the nurse about my baby's nursing, and she seemed short with me. When I hung up with her I sat down with the baby to try and feed her again, but I couldn't stop thinking about why the nurse was acting like that. I just ended up feeling really miserable. I think about an 8. It all happened around 4pm, right when the baby usually gets fussy and I'm all alone in the house."*

After you've gathered this information, and noted the link between context, behavior and mood (e.g., *"So, you were alone, the baby was crying, you sought out help, which you thought seemed a little rude, and you sat down and kept going over it in your head, which lead to you feeling worse. Is that right?"*), use the chart to jot down what the client said, checking in with her to ensure you're accurately reflecting her comments. It is then useful to talk about the importance of becoming aware of patterns between behavior and mood and using the tracking form to do this.

Therapist Script:

"You mentioned that you've been down all week. Your chart shows that you were down mainly during the evening when you arrived home from work. Can you tell me more about how you feel during that time?"

♀ Be aware of your client's time and abilities when assigning the tracking log for homework. Also, allow the tracking to change for women, especially after they give birth. One such modification is for a client to simply write down a number to rate her mood for the day and brief details about a major event(s) that day.

Tips for exploring the mood tracking log and weekly activities:

It is important to know what is going on in the client's environment that contributes to negative mood (e.g., staying at home and dwelling on negative life circumstances), and then test different actions that may improve her mood and meet life goals (e.g., taking a break from caretaking to get needed rest).

Therapists and clients should look for links between mood and activity. In particular, look for activities the client isn't engaging in (e.g., previously enjoyed activities, important, goal oriented activity – or an imbalance in activities). What environmental factors are involved in how the client is feeling? (e.g., before the client may not have had many assertive conversations with her partner, but now pregnant there may be more of a need to talk about important matters, and avoidance of these conversations may now contribute to depressed mood). How is the client responding to these environmental factors that may be maintaining negative feelings?

It is useful to compare clients' activity charts with their perceptions of their level of activity and mood from the previous week. For instance, a client may report feeling depressed for most of the week, although the activity chart may reveal variations in mood. It is also important to pay attention to difficult situations, activities and times of day, and work on strategies to improve these times. The therapist should pay attention to **depression loops**, or times when the individual's attempts to cope with difficult or depressing feelings makes the depression worse. The therapist should help the client to

identify behaviors that worsened mood (e.g., escape behaviors) and to implement alternative coping strategies.

Example of depression loop:

I look at the laundry, the dishes, and the house and think it's a mess, I don't know where to start.

When I feel overwhelmed, I take a nap to get away from it all.

When I wake up from the nap, I feel useless, lazy, even more overwhelmed. I think "I can't do this. I'm a horrible mom."

Intervention 1C: Introduce the TRAP Model

A great deal of behavior is habitual, which means it occurs outside of awareness. Changing habits requires that the client learn to recognize behavioral patterns. Also, during pregnancy and the postpartum period, a woman may feel that she is unable to engage in activities that she previously did or that she does not have any options available to her. For example, she may feel that because she mainly went to the bar with her friends before her pregnancy and is not currently drinking that she cannot hang out with them anymore. Therefore, when her friends call, she may not answer the telephone, and she ends up staying home alone feeling down about herself.

In explaining the logic behind mood and behavior tracking, clients should be introduced to the **TRAP Model**.

TRAP stands for:

Triggers**, R**esponses and **A**voidance **P**atterns

Triggers: Situations or feelings that affect you.
A trigger may be the rush of adrenaline you feel when your baby cries, a thought that another mother may be judging you critically, or the way someone holds your baby.
.
Responses: Reactions to a trigger.
Responses to triggers are often emotional. Sometimes these emotions can feel good, other times painful or difficult. They can be feelings of sadness, fear, anxiety or anger.

Avoidance Pattern: The behaviour you engage in when you're feeling low. For example, you might procrastinate, suppress your feelings, withdraw, not express your feelings to other people, give up activities you were good at, or spend your time thinking about things rather than doing. Sometimes you immerse yourself in other activities (e.g. taking care of others) to avoid the situation that is causing you distress).

An example of a TRAP

What is the issue? "Interactions with friends and other mums seldom happen, I need to have more social and adult contact."

Circumstance - Monday lunchtime, finally got the baby to sleep after she had been fussing for 3 hours **What was your Trigger?** The phone went
Response - I felt anxious so avoided the phone. I didn't want to speak to anyone as I was sure that it would be someone trying to persuade me to go out this afternoon. **How did you Avoid it?** I let the phone go to answer phone and distracted myself on the PC.

Consequence of your avoidance? Relieved at first as I didn't have to talk and go out, but after listening to the answer phone I then sat around feeling guilty about letting my friend and myself down.

The TRAP model can be a useful tool towards identifying avoidance behaviors. Keep in mind that it is just a tool – the key objective is to help the client develop and understanding of the context in which she engages in unhelpful avoidance behaviors.

Therapist Script:

“Can we try applying this model to a recent situation you encountered? What connections do you see between your mood, events, and behaviors?”

“What patterns to do you see in these stressful situations?”

Goal 2: Building Behavioral Alternatives

After identifying links between depressed mood and behavior, it is important to help the client use that information to make specific changes in her behavior. Clients are encouraged to take an experimental approach to therapy. This allows them to step back from the changes they're making and take a “well, let's try and see if this works out, and if it doesn't what might happen” approach.

Therapist Script:

“While we try coming up with different behaviors to try, let's use all experiences as information about what is helpful and unhelpful for you. If something doesn't work for you, that's still good information. Therefore, there are no “bad” tries.”

The TRAC model flows nicely from the TRAP model and can help clients recognize different ways of responding to difficult situations.

TRAC: Triggers**, R**esponses and **A**lternative **C**oping

Work with the client on the TRAP she has worked up to identify an alternative coping response.

In all cases, the therapist should work towards helping the client determine alternative behaviors that adhere to the following principles:

"ACES"

Action: Action with meaning and goal focused

Concrete: "How" is the client going to do the things necessary to achieve her goals?

Experiential: An openness to trying out new behaviors is key as it is a process of learning what works for her.

Specific: Planned new behaviors should be clear and easy to follow

(thanks to Ed Watkins for sharing this helpful acronym)

"You've described feeling scared and overwhelmed as soon as you leave the doctor's office. And often, when you feel that way you go to bed which then makes you feel more tired. What do you think would help you feel more like "I can handle this"?

Additional Suggestions for Therapists:

Focus on Mastery-pleasure activities – It is important to give the client the opportunity to accomplish tasks. Accomplishments improve people's sense that they can do things and are making progress, and can lead to positive mood and well-being (and a sense that they can do more!)

Prepare for Potential Barriers and Stress Strengths – Be realistic that each woman may have a different set of barriers. Also, focus on what can encourage her and draw out her strengths. Work together to develop methods that aid her in completing assignments such as setting an activity into her schedule, enlisting other people's help, and setting up physical surroundings that are conducive to change.

Intervention 2A: Determine Alternative Behaviors

In determining alternatives, it is helpful to:

A **Assess mood and behaviour**
C **Choose alternative behaviours (useful to**

brainstorm the alternative)

T **Try out the alternative**

I **Integrate these changes into the client's life**

O **Observe the results**

N **Now evaluate**

Therapist and client should continually work together to understand the link between current actions and mood, and collaborate on finding alternative ways to increase the instances of healthy, goal-oriented behaviors that improve mood.

Therapist Script:

"While that activity didn't turn out the way we planned, that doesn't mean this was a "failure". On the contrary, it is really important to know that this is not helpful for you, and perhaps we should look for activities that include childcare."

"It sounds like that activity had a very positive effect for you—you felt joyful, excited, and proud of yourself. Is that right? And it sounds like it is in line with your larger goal of _____. "

Therapist Guidance:

Brainstorming new strategies or behaviors should be an open ended, non-judgmental process. The goal is to get as many ideas as possible. When selecting an alternative behavior, it is important that the behavior be both do-able and concrete. As clients are observing the effect of the new behavior on their mood, it is useful to remind them to keep an open "experimental" perspective. That is, no exercise can fail. If the exercise results in an improvement in mood, fantastic. If not, this is also useful information. Frequently, setting new goals is not difficult, but rather it is the process of implementing them that is. It is important to normalize this process for the client.

It is also important to stay focused on what is meaningful for the client. Also, remind her of her strengths and life goals. Affirm her progress (tracking logs can help with seeing change!). Applaud her efforts. Be her ally in bringing change and decreasing the symptoms of depression. When difficulties in completing therapy assignments are encountered, it is important to help clients identify concrete barriers and modifications necessary to applying new behaviors. This is not "just do it" therapy.

Therapist Script:

"Since you run out of energy quickly, could we explore meaningful activities that you can do in shorter time periods and could do frequently so you have time to rest?"

♀ As your client progresses through her pregnancy, her behavior abilities may change, even rapidly especially in her third trimester.

Stress self-care as her physical discomforts occur. Discuss self-care as behavior goal. Connecting her care to care for her child may be helpful in achieving this goal.

In the postpartum period, she may be physically recovering from delivery and experiencing change on emotional and physical levels. Find activities that stress self-care and help with stress relief/relaxation to deal with these discomforts.

It is important to not blame or judge the patterned coping mechanisms, but rather explore together with the client how these avoidance patterns work for the client and collaborate to find more helpful alternatives. Encourage and stress her strengths as she works on alternatives.

Therapist Script:

"Depression often makes us feel like we can't do very much. How would it feel to look at brief activities? For example, when you are sitting on the couch, what to do you think about getting up and walking around the house just once?"

"What do you need to do today for you to feel good about yourself?"

Intervention 2B: Graded Task Assignments

In helping clients choose an alternative method of coping, it is often helpful to first pick smaller tasks that work towards a larger goal, and then build on these tasks in a hierarchal fashion as progress is made. This process helps the client break her larger goals down into smaller pieces, builds on higher success probabilities, and is more likely to lead to feelings of self-efficacy and motivation.

Intervention 2C: Exploration of life goals

Alternative behaviors should be consistent with the client's life or mood goals. It is helpful to first use the Life Goals Assessment forms to help identify specific goals within a given domain, and to choose priority goals. These goals can make behaviors more meaningful.

Insert example of life goals assessment here

Therapist Script:

Example of role playing

Intervention 2D: Role-playing and Therapist Modeling of Strategies

Clients frequently state, "I know what's good for me, but I just don't feel able to do it." Breaking behaviors down into do-able components during the therapy session and increasing experiential opportunities to act out those components are often critical pieces to improving action.

Always go back to the "no-fail" assignment rule when clients feel they have not accomplished their weekly exercises. Often, there's a lot to be learned from not accomplishing an exercise. For instance, it can be useful to find out if maybe the timing or size of the task was not conducive to getting it done, and rearranging the task to make it more do-able. This process can be a useful exercise in helping clients learn to reassess and problem solve around "failures."

Intervention 2E: Problem solving

Try these steps to work through a barrier:

I. Identify the problem

II. Define the problem

III. Brainstorm solutions

IV. Pick a solution

V. Implement the solution

VI. Assess how the solution went

Therapist Script:

"Depression often makes us feel like we can't very much. Sometimes we wait for motivation before we act, and sometimes we act in order to build motivation."

VII. Trouble shooting

Intervention 2F: Acting Toward a goal

This approach adheres to the BA idea that feelings and thoughts often follow actions. Sad mood tells people to avoid, and stay immobile. People often say that they are waiting to feel motivated and then will do something. BA says, "do something first, and motivation will follow."

The metaphor of "priming the pump" may be helpful in explaining this idea. For example, when trying to get water from a pump, one has to work the pump in order to start the water flowing. The immediate benefit is not reached until after some effort. This type of metaphor may provide inspiration to clients who do not feel motivated and are waiting for motivation before acting. *Activity can create more activity*.

Intervention 2G: Getting balance

Barriers can often come in commonly appearing packages. For pregnant women, this can include busyness and an imbalance in types of activities. For instance, mothers of small children may be running circles around themselves caring for their children and their home while avoiding resolving uncomfortable problems, or engaging in pleasurable or important goals. Sometimes part of this problem may be due to a shift in life activities and a lack of what to do in these new circumstances (who do I hang out with now? How do I meet those people?)

It can be helpful to look at the types of activities women are engaged in and label them – for instance, using the labels, routine, important and pleasurable. If there is a significant imbalance, it may be useful to talk the woman about prioritizing activities that she's lacking, and scaling back on

activities that aren't as helpful to her mood (e.g., is it really necessary to Hoover the house everyday?)

Sample Session Structure

1.) Debrief the client's weekly activities. Draw links between mood and context.

2.) Examine how the client is responding to life circumstances.

3.) Assess progress towards client's identified areas of work. These areas should be consistent with her life goals.

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Therapist Note:

Therapists should work with clients in an ongoing fashion to make alternative behaviors do-able. Women may have unreasonable expectations about what they "should" be doing. Sometimes, normalization about the stresses and pressures of motherhood may be enough to encourage the client to adapt a kinder level of activation activities. Such an approach may also be congruent with a behavioral "self-care" goal. However, if the woman's therapy achievement expectations significantly interferes with her ability to progress with behavioral strategies, then the therapist and client may wish to consider using approaches in the cognitive module of this treatment to restructure cognitive expectations.

Therapists should address anxiety. Anxiety can be a significant component in perinatal depression. Both cognitive and behavioral strategies may be useful in helping mothers manage their anxiety. Therapeutic efforts to ameliorate anxiety should always be made in collaboration with the client.

Normalization and psychoeducation may be appropriate in some instances (e.g., listening to mom's concerns about

child's eating habits, and discussing ways to gain additional information from other mother's or medical professionals). In other circumstances, empathy and active listening about mom's worries may prove useful. Some mothers express the desire to have a professional just "say it's okay." (e.g., if you've held the baby, and checked baby's diaper, but baby is still fussing, it's okay to put baby in a safe place and give yourself a couple of minutes break). Asking a professional for help and guidance may be a behavioral activation goal.

In other circumstances though, mothers may need more than reassurance, professional guidance, or empathy. If mom's worries are primarily cognitive in nature, (e.g., catastrophizing about the long-term emotional consequences associated with crib sleep), then it may be appropriate to utilize cognitive restructuring strategies described in the cognitive module of this treatment manual.

Case Examples

Module

3

Enhancing Social Support

"I'm all alone in this pregnancy. No one goes with me to my doctor's appointments, and no one hangs out with me anymore."

"We share a wonderful connection, but he's not the best at seeing what needs to be done on an all-the-time basis. So that can create some isolation too because you are the only one who notices all the dishes sitting there or whatever it happens to be. That can also play a little more of a stress factor.."

This module addresses the role of support and relationships in regards to depression. Any life change or stressful event, such as pregnancy, can increase the need for additional social support either because existing relationships have changed or extra support is needed. Whether or not this is a first pregnancy, many aspects of a woman's life change at this time, each of which may impact social support. For example, pregnancy can lead to changes in the relationship with the baby's father, significant others, and family members, as well as her work or school involvement and needs for support from health care providers and community agencies. As a result, women may need to learn different ways of

communicating, specifically, asking directly and clearly for what they need from others.

Background Information

Regardless of the causes of depression, the symptoms and illness occur in a social context. A great deal of research has shown that depression can lead to significant social impairment (such as making it difficult to parent and work). In addition, conflict with the primary partner relationship for women has been consistently linked to vulnerability to depression, and is a risk factor for perinatal depression. "Conflict" can take a number of forms, and may not necessarily show as overt arguments, but may also take the form of un-expressed dissatisfaction with the relationship that impacts mood.

♀ AMONG PREGNANT AND POSTPARTUM WOMEN, FEELINGS OF LONELINESS AND ISOLATION CAN BE OVERWHELMING. IT IS IMPORTANT TO DISCUSS THEIR EXPECTATIONS AROUND THE TYPE OF SUPPORT THEY WANT TO HAVE AND TO CREATIVELY FIND WAYS OF EFFECTIVELY ACHIEVING THAT SUPPORT.

In the perinatal period, women may find themselves dealing with many new adjustments. Their attempts to gather support may have been less successful than they expected. In the end, they may have learned to manage the stress of their current situation through avoidance and passive behaviors. These behaviors are often discussed as coping mechanisms.

We have seen several examples of social support difficulties that may either emerge or worsen around the time of pregnancy:

- Conflict with the baby's father
- Conflict with significant other(s)

- Conflict with family of origin in relation to the pregnancy
- Feelings of social isolation from friends, family, co-workers due to the pregnancy or new baby
- Fear and hesitation around asking for help from others
- Dissatisfaction with help or support from physicians, other health care providers or staff at community agencies

P: "I was just upset because he hasn't taken me to any doctor appointments. At the beginning, he came to all my appointments. He was very supportive, just the perfect prince in pregnancy, and then 3 months came, and it just went sour."

Selection of Module

"You've expressed that stress from interactions with your family is your primary concern. Can we talk more about these interactions?"

Use this module if the woman indicates that mood distress and other symptoms seem centrally related to a disruption in social support and/or feelings of loneliness and isolation that appear to result from ineffective communication.

Key Principles

- Social support difficulties should always be addressed in the context of impact on mood and other symptoms (i.e. distress)
- The therapist has no investment in any particular decision or resolution about the problem and should maintain the focus on eliciting what would work for the client

- Clients are not told that their communication is "wrong", but rather the therapist and client work together to discover communication styles and patterns that are helpful and unhelpful for each individual client.

Goals and Strategies for Module

The purpose of Cognitive Restructuring is to:

1. To carefully assess and identify social support needs and difficulties
2. To identify and improve specific areas of communication difficulty
3. To help the client bring about needed social support through interpersonal problem solving, communication changes and setting realistic expectations from others.

Overview of Goals, Interventions, and Handouts

Goals		Techniques	Supplements
1. Assess social support needs and difficulties	1A	Conduct interview regarding social support history	
	1B	Develop awareness of mood-social support link	
2. Identify target area	2A	Collaboratively determine area of focus	
	2B	Obtain client's consent to proceed in this area	
3. Focus on solving interpersonal concern	3A	Communication Analysis	
	3B	Role Play	
	3C	Brainstorming	
	3D	**Decision Analysis**	

NOTE: Not all techniques will be used for all clients, and some women may need more time than others to complete each goal. Remember to keep treatment individualized and flexible.

Goal 1. Assess social support needs and difficulties

It is important to collect detailed and thorough information about her experiences, needs, expectations, disappointments, and previous successes in the realm of social support and communication.

Tell me about the ways in which you feel supported and not supported by the people in your life.

What are the satisfying and dissatisfying aspects of this important relationship?

What are the specific ways in which you wish things were different with this person in your life?

Intervention 1A: Conduct Interview of Social Support History

Begin with a thorough **assessment of her social support difficulties**, including the origins and current status of the difficulties. Try to get detailed and specific information.

During this assessment you are listening for:

a) Specific social support needs (both emotional and instrumental),

b) Specific changes the client needs in the relationship,

c) Evidence of communication skills that are needed (see unhelpful communication patterns in section 3) and

d) What the client has tried already and what might be realistic strategies to bring about a change.

At this stage and throughout, remember to reflect and summarize throughout to make sure you are understanding what the client is saying and intending to communicate about the issue. Always ask permission before giving suggestions and follow up with a quick assessment of how the person sees the suggestion. Use the pattern of eliciting information, providing a summary, and eliciting more information.

Suggested questions:

- Tell me about the ways in which you feel supported and not supported by the people in your life? Specific examples should be provided.

- What are the satisfying and dissatisfying aspects of each important relationship? (or, What are the ups and downs of each relationship?)

- What are the specific ways in which you wish things would be different with ___?

- Was there a time when things were closer to what you wanted and then changed? If yes, what happened, tell me what changed…what was it like then and what is it like now?

- What things have you tried to bring about the changes in this relationship that you want? What worked and what did not work? What do you think would work better?

- What would ________ say about this if he / she were here? What would their perspective be?

Your client may bring up stress from her primary intimate relationship or other significant others. Since the perinatal period is a time of such intense transitions, she may be hesitant to bring up the depth of her sense of unhappiness or dissatisfaction with her primary relationship(s). It is important to remain non-judgmental and to respect her decisions around her meaningful relationships. When she brings up a meaningful relationship, ask her first what is positive about the relationship, what she finds nurturing about it, and what that person does really well—this helps recognize the complexity of the relationship. If this is a relationship she is not happy with, she may be hesitant to end the relationship because of the pregnancy/new baby demands. This hesitancy should be normalized and respected. It may be helpful to discuss with her ways to get her needs met in this current situation.

Conjoint Interpersonal Assessment Session: As mentioned in the assessment module, women often benefit from having a significant other join one session of treatment. If the

interpersonal focus has been determined before a partner joins the session, this may be an opportunity to assess the partner's perspective on the interpersonal concern. This can be very useful in helping the therapist gauge how receptive the partner will be to changes in communication style or how supportive the partner is willing to be during the pregnancy. It is not uncommon for clients to perceive their partners as less supportive or receptive than the partner or others may see them. On the other hand, if a partner appears much less supportive than the client describes, this is also useful information for the therapist. See the case example at the end of this module for an example of conjoint interpersonal assessment.

The following may be helpful goals for a conjoint session:

- Explore the significant other's experience of the client's depression. (e.g., What changes have you noticed? What has this been like for you? What is it like for you to be here?)

- Affirm the partner's commitment to the relationship. (e.g., thank you for coming, you are a very important person in her life, you being able to show your support in this way is helpful). Listen for and reinforce words of commitment and support (e.g., you really care about her, you're very concerned, it's clear that you want to support her through this time).

- Learn about partner's perspective on conflict or low support. For example, if the area is communication, you may ask, "What do you like about the way the two of you communicate as a couple?" followed by, "What would you like to see happen differently in the way you communicate?" If partner sees client as primarily responsible for communication difficulties, you may ask, "to what extent do you feel like you able to understand where she's coming from on this?"

- Compare client's perceptions with partner's. Frequently check in with the client after eliciting comments from the partner, such as "What's it like for you to hear him say this?" or "How does this fit with the way you see the issue?"

Intervention 1B: Establish awareness of the link between mood and social support

Ask the client questions about how the social support interactions make her feel. Gather information about the changes in her mood. Use the mood/behavior, or the event/thought/mood, or any other log that helps identify the role of these interactions on her mood as well.

How did you feel before you spoke with this person?

How did you feel after talking with this person?

Sample questions include:

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- When you finished that conversation with your partner, how did you feel?
- When you think about how you wish things were different, what goes through your mind? How does that make you feel?
- What was your mood like before this conversation with X, and after?

Goal 2: Identify Target Area

It is important to pick a specific area to focus on and to work with the client to figure out that focus. The target should be important and meaningful for the client. By work with her, this action shows that her needs are the central focus of the therapy. Also, this collaboration provides her with the tools to use these interventions outside of the therapy sessions.

Intervention 2A: Collaboratively Determine Area of Focus

"You've shared several examples of how your relationships have been helpful and unhelpful. Which of these do you feel is contributing to/ intensifying your stress/depression the most?"

Once the specific interpersonal problems and social support needs are understood by you and the client, identify the area that seems to have the most impact on the client's distress. For example:

"You talked about a number of things that have happened in your relationships that have not been working the way you want and are not meeting your needs (list them using client's language). Of all of those, which do you think has the most impact on your stress / depression?"

Intervention 2B: Obtain client's consent to proceed in this area

"We've discussed how social interactions affect your mood. You've pinpointed the conversations with your mother as having a severe negative impact on your mood. How do you feel about working together to look at possible communication changes that may help your mood and interactions?"

A sample structure for obtaining permission from the client is to provide information about the interventions, summarize what the client has told you about her target relationship and its impact on her mood, provide hope and validate her strengths, and then ask permission to proceed with working more in depth in her target area.

"We know from research and clinical experience that problems with feeling supported by others (such as - list specific problem) are key to health and well being around the time of pregnancy. From what you have told me, this issue with (list specific problem) has certainly made you feel worse. We also know that people begin to feel better if they can directly address these social needs. In this part of the treatment, we will work together on getting these needs met better. We will do this by brainstorming about options and making some changes in the way you communicate with each other. What do you think about that?"

At this point, the client may express some degree of hopelessness to bring about any change. If so, reassure her that you understand why it is she feels that way (normalize), and that a fresh perspective on the situation and some fine tuning of skills are very likely to help. Affirmation of the client's strengths to bring about the changes is critical here:

"You are someone with very good communication skills already, and you have overcome some very difficult things, you have a lot of strength that will help you get what you need here."

There also may be some ambivalence about focusing on a particular interpersonal problem in therapy. Pay attention to signs of ambivalence such as "I think he will come around soon enough"; " I made it sound pretty bad, but he actually is very good for me", or "I really don't think I need to talk about that". At this point, you can reflect the ambivalence with reflection such as:

Client: "I made it sound pretty bad, but he actually is very good for me"

Therapist: "He certainly has a lot of strengths, and you don't want me to think badly of him".

P: "Yes, he really is a good guy, just makes me mad sometimes"

T: "That sounds quite normal, every relationship has ups and downs. Our job here would be to help you make some adjustments in the relationship that builds on the ups and helps you get a bit more of what you need more often. What do you think about this?"

Note that at each point, you are reflecting what you hear from the client, normalizing, providing some degree of psycho-education about this part of the treatment, and eliciting the client's consent.

If the degree of resistance still seems high (i.e. you are not able to elicit consent):

1. State that you understand her uncertainty and want to make sure this treatment is customized to her needs (i.e., will work best for them). Ask what she thinks would be the best focus and go with that.

2. Ask her permission to revisit this issue later if needed:

"I understand you are not sure that this will be useful to you. You are the best judge of what you need. What do you think would be the most useful focus to you at this point (reflect what is stated). Would it be ok if we check in about this issue with ______ a bit later to see if it has gotten better, worse or stayed the same?"

Goal 3: Focus on Solving Interpersonal Problem

If the client provides consent to work with you on the social support problem, proceed to focus on solving the interpersonal problem(s) by using **Communication Analyses** and. **Decision Analyses.**

There are several interventions that can be used to re-shape communication, including the use of Role Play, Brainstorming, and Decision Analysis. These techniques are often used together.

As discussed, distress often occurs as a result of a stressor that is made worse by insufficient social support, which may be due to low levels of available support, but also communication difficulties. At a basic level, <u>it is very common for people to communicate things in ways that are not effective in eliciting the response that is wanted or needed</u>. It is important to normalize that evaluating communication patterns and styles is

common and it is important to **not** imply that her communication style is "wrong".

♀ **Women and their partners/family members may have very different ideas about how to provide support. For example, a woman may want her partner to attend her prenatal visits with her, but may feel as though "I shouldn't have to ask, he should want to be there." Conversely, the woman may have family members who expect to be very involved in the care of the new baby, while she views this as an intrusion or lack of confidence in her mothering. reassure her that differences in expectations are common, and often pose a challenge for communicating with well-meaning friends and family.**

Intervention 3A: Communication Analysis

The goals of communication analysis are to:

a) Help the client become aware of her communication patterns specific to the social support problems

b) Recognize how the ways of communicating may make the problem worse or better

c) Help her to learn to communicate more effectively (i.e. in a way that increases the likelihood that she will get what she needs).

It is most helpful to start with (if possible) the client's description of a specific conversation or interaction with a significant other that typifies what is most dissatisfying to her. You will learn the most specific information about possible unhelpful communication by obtaining verbatim accounts of interactions. Some clients will need some coaching on this. Here is an example:

T: "You're not satisfied with the fact that your husband is not home as much as you would like him to be and that you've tried to talk with him about that. Would you tell me about a specific example of a time you've talked about it that shows how it is likely to go?"

P: "Well, I usually tell him that I miss him when he is gone, but he sort of ignores me and nothing changes"

T: "I see. It would really help me if you can tell me exactly what you say, then what he says, etc, as if I were there observing the whole thing."

P: " Well, I say something like, "why are you home so late"

T: (stop client here) "Are those pretty much the exact words?"

P: "yes"

T: "Ok, then what did he say in response"

The above is a case in which the client needs minimal coaching to describe a specific interaction. Some clients will find this much more difficult. In those cases, start with whatever the client is able to describe and try to work with that rather than risk making her feel unable to do something you are asking.

Here you are listening for any **unhelpful communication patterns** such as:

- **Indirect communication such as not stating clearly and directly what is needed**

A new mom is feeling overwhelmed by the amount of laundry piling up and wishes her partner would do the laundry while she is nursing the baby. Instead of asking her partner to do the laundry, she says, "The laundry is really piling up. Its amazing how many bibs the baby goes through." Her partner agrees with her. When her partner does not do the laundry, she feels upset, pouts, and feels down about not having support.

A pregnant woman is feeling isolated because of her pregnancy. When she is talking with a friend, she makes the comment that she misses going to the movies instead of asking her friend if they can go to movies. After she hangs up the telephone, she feels down, all alone, and thinks that no one wants to go to movies with her.

- **Incorrectly assuming the person knows what she wants / needs**

A pregnant woman is feeling tired and has worked all day. When she comes home, she lays down on the couch. She expects that her mother (whom she lives with) will make dinner since she is so tired. Her mom doesn't make dinner and the woman feels like her mom doesn't care about her needs.

A mom has been at home all day alone with the new baby. The baby cried much of the day and mom is feeling very tired and overwhelmed. When her partner gets home, she doesn't tell him that she needs help with some household chores and baby. When he doesn't help, she gets upset.

- **Un-necessarily blaming or hostile communications that evoke defensiveness**
- **"Giving up" on a request prematurely**
- **Difficulty asserting needs and wishes clearly and calmly**

After you have identified unhelpful communication patterns or styles (i.e. ways of communicating or not communicating that interfere with the client's effectiveness in getting the response she wants), the second step is to help her shape the communication. You can introduce this and elicit the client's consent by saying:

"From what you have told me, you have not been getting the response you want here. You have good communication skills

already, and I think we can work together on shaping things in order to increase the chance you will get the response you want."

It is important that the desired/needed response is realistic. If you assess that the client may have expectations from the relationship or from the interactions that are un-realistic, that should be addressed. See "Re-assessing Expectations" below.

Intervention 3B: Role Play

In Role Play, you should decide how to structure it based on your assessment of the client's unhelpful communication patterns or style or her identified goal(s). For example, if you want to assess the likely response of the significant other, you can play the role of the client and act out her typical way of communicating. She can play the role of the significant other. For example:

T: "I want to get a sense of how ________ is likely to respond to you, so I will be you. Please respond the way __________ would be likely to respond to this knowing him / her"

If your goal is to model a possibly more effective way of communicating something, you may also play the role of being the client. After your attempt at modeling, the following questions should be asked:

- "What would it be like for you to put it that way?"
- "How would ___________ likely respond if you said it that way?"
- "Is that what you would want?"
    - If yes, "Would you be willing to try that?" "What would get in the way?" "When would be the best time?" "I'd like you to try that before we meet next time and we can explore together what worked, what did not work and what would be better. If you do not get to do it before next time, we can talk about the barriers etc" "How does that sound (EPE)?"

- If no or if client expresses that your model will not work "What would you want as the outcome?" "Knowing ________ , what might work better to get the response you want?" Then go to "Would you be willing to try that?", "What are barriers to using this different style?" Explore barriers, assign, etc.

Modeling of potentially more effective communication resembles Decision Analysis (see below), but it is Decision Analyses that is specific to communication.

Intervention 3C: Brainstorming

Brainstorming may also be combined with role play or decision analysis, guided by the following:

"This is a tough problem and you have tried several things already. Maybe we can put our heads together and think of some other things to try that realistically, knowing __________, might work better."

Brainstorming is intended to be an open share time; stress creativity. It is important to simply come up with as many ideas as possible and re-frame from immediately judging or dismissing any suggestions.

Generate several options and use Decision Analyses to determine the best option for the client to try in the upcoming week.

♀ Your client may feel that she is all alone and this may bring her a lot of distress, especially as she navigates the uncertainty of the perinatal period. When she states that she is alone, it may be useful to explore how true that statement is and to explore options for gathering support. Some women find solace in support groups, mom groups, online support networks, and community support. Brainstorming can include these types of support providers.

Intervention 3D: Decision Analysis

Decision Analysis can be used anytime the client has any interpersonal problem to be solved. The emphasis should be on

- Determining the specific problem and the client's desired outcome (e.g. *"What exactly and realistically would you like to see happen here or to change?"*)
- Generating several options for addressing the problem (or communicating)
- Going through a series of queries in response to each option generated:

What would it be like for you to do / say that?

What is likely to happen as a result?

How will that make you feel?

Is that what you want?

If **YES**, address barriers and assign;

If **NO**, *what other option might work better for you?*

Repeat these questions for each option.

The overall goal is for the client to learn to analyze problems in this way outside of the session and to be able to identify communication or appraisal difficulties that might work or not work. This is an empowering process for her to be able to assess her patterns and styles to improve situations in the present and in the future.

Throughout the social support module, there should be an explicit focus on the **link between social support and mood / distress / stress**. At several points, you should inquire about how the improved or problematic social support is impacting the client and her mood.

For example, when following up with the weekly assignments, you want to ask how the altered communication or interaction impacted her mood / stress / distress level, and what about it worked or did not work. This information will be used to iteratively shape the focus.

3E: Communciating with Medical Providers

Taking P.A.R.T

No such thing as a stupid question

P: Prepare

Prepare an agenda before going to your appointment and focus on the reason for your appointment. What are your concerns?

Write down a list of questions and concerns.

Between appointments take notes about your symptoms or concerns.

Prior to your doctor appointment, mark the items on your list that are most important to discuss during the appointment.

At the beginning of the appointment, tell your doctor/nurse your concerns, perhaps show him/her your list and point out your priorities.

A: Ask

You have a right to ask as many questions as you need to in order to understand and have the information you need.

Think about answers your doctor could give that would lead to more questions. For example, asking "Will I need to be induced?" If yes, then "How will that work?"

R: Repeat

Repeat the important points to see if you have correctly heard the answers to your questions.

T: Take Action

Before the end of your visit, double check to make you understand your next steps and the doctor's next steps.

Ask for any written instructions or information that would be helpful.

Full instructions and call with any further questions or concerns.

Sample Session Structure

1. Debrief client's weekly thoughts, activities and mood. Draw links between thoughts, mood and context.

2. Work on exploring social support issues, getting very detailed information

3. Identify a target area to work on—i.e. relationship with client's mother

4. Communication analysis of indirect communication with mother and ramifications on client's mood

Therapist Note:

Depressed individuals can be alert to feedback that they are "wrong" in the way they communicate. Keep the focus on working together with the client to explore communication methods that are helpful and unhelpful (effective and ineffective) for her. It is important to be sensitive and thoughtful about the difficulties depressed clients have had in their lives.

It is helpful to (a) discuss how social support interactions and moods are connected, and (b) talk about how communication patterns may or may not be working for client in her current circumstances (c) not judge her choices and (d) work together to try out potentially more effective patterns.

Throughout the social support module, there should be an explicit focus on the link between social support and mood / distress / stress. At several points, you should inquire about how the improved or problematic social support is impacting the client and her mood.

The overall goal is for the client to learn to analyze problems in this way outside of the session and to be able to identify communication or appraisal difficulties that might work or not work. This is an empowering process for her to be able to assess her patterns and styles to improve situations in the present and in the future.

Summary:

Therapists should attend to:

- Personalized care of exploring social support history and the needs for each client;

- Communication styles and patterns that are used by the client that are not effective in helping her get what she needs;
- The client's expectations, methods of obtaining needs, and outcomes;
- Signs that the client is feeling blamed or is feeling as though she is communicating in the "wrong" manner.

Case Examples:

Description of the client

Information of Assessment:

First Social Support session:

Sample dialogue

Transcribe sample session and Create one simple, "goes well" session

Insert frames with "coding" the techniques and reference information

Insert symbols by "coding" session

Module

4

Cognitive Restructuring

"The children's needs come before mine because that's just the way that I think.. I just feel that they're my children and they deserve everything."

This module addresses the role of thoughts in influencing depression. Cognitive restructuring is based on the premise that our thoughts have an important role in how we both behave and feel. All humans have experiences. According to cognitive theory, our thoughts influence our mood, both positively and negatively. Therefore, how we interpret events shapes how we feel as well as how we respond to those events.

For example, a mother may be alone with a seemingly inconsolable infant. The mother may think:

"I don't know what to do! Why won't my child stop crying? Why can't I help her? Will this ever end?" and feel **anxious**

Or

"I don't know what to do! Why can't I handle this? There must be something wrong with me because I can't help my child. A good mother would be able to cope with this." And feel **down, anxious, unsettled, hopeless**

Or

"What is wrong with this child? I've done everything I can think of, and this baby just won't calm down!" and feel **angry and frustrated**

Or

"I don't know what to do! I know moms feel this way though. We'll just have to hang in there until we find something that works, or until this baby just exhausts him/herself." And feel as **content, confident, hopeful** as can be expected given the circumstances!

Likewise, the mother described above may behave differently based on her thoughts and feelings. If she was feeling down and hopeless, she might give up attempts to calm her baby. The "confident/hopeful" mother, however, might continue to try and find ways to calm the baby, or might remain present with the baby while s/he cries.

♀ AMONG PREGNANT AND POSTPARTUM WOMEN, THOUGHTS HAVE A DIRECT IMPACT ON BEHAVIORS AND MOOD. UNCOVERING THESE PATTERNS IS USEFUL IN LESSENING THE INTENSITY OF DEPRESSION. IT IS ESPECIALLY IMPORTANT TO LOOK AT EACH CLIENT'S IDEAS ABOUT PREGNANCY AND PARENTHOOD AND TO EXPLORE IF THESE THOUGHTS ARE HELPFUL AND IN LINE WITH HER EXPERIENCES.

The role of Cognitive Restructuring is not to blame a client for her thoughts or to suggest that her thoughts cause her depression. The purpose is to look at how thoughts influence her mood and behaviors and to examine how helpful or unhelpful specific thought patterns are.

Background Information

Depression and negative thought patterns are linked in a cycle: depression can cause negative thinking, and negative thinking helps to maintain depressive symptoms. Three domains have been found to be strongly linked to depressive symptoms, often called the "depressive triad" of thinking:

♀ **PREGANCY AND PARENTHOOD OFTEN INTRODUCE MANY "UNKNOWNS" AND UNEXPECTED EXPERIENCES. WOMEN'S THOUGHTS ABOUT THESE EXPERIENCES AND THEMSELVES CAN INTENSIFY THEIR DEPRESSION IF THEY HAVE NEGATIVE THOUGHT PATTERNS.**

1. **Harsh self-evaluation**: Depressed individuals may find that negative events and failures are very easy to recall, but remembering positive things about themselves is very difficult. For example, a new mother may easily recall every time that she has been criticized or felt incompetent in her parenting, but may forget positive experiences in which she handled things very well.

2. **Negative bias about the situation**: Depression can also affect the way women interpret events in the world around them. Feelings of hopelessness may minimize positive events when they do occur.

3. **Negative expectations about the future**: During a depressive episode, women may overestimate the likelihood that negative events will occur, and may be overwhelmed by beliefs that nothing will change for them.

The goal of focusing on thought patterns in this treatment is to recognize unhelpful thoughts and interrupt the link between negative thinking and depression. It is important to note that the goal of cognitive interventions is not to replace negative biases with positive biases (e.g., it is not helpful for a woman to convince herself that everyone loves me, things will always work out, etc.). The goal instead is to create balanced, realistic

thoughts that are helpful in overcoming depression, rather than unhelpful.

Although there may be no single correct way to parent every child, the wealth and diversity of parenting materials available to new parents is indicative of the level of ambiguity, importance, and concern that parents and society place on raising children. Women negotiating this territory may find themselves at a loss. Parenting is uncertain! For women without appropriate and/or trusted supports, their paths may be even more confusing. It is not surprising then that many mothers adopt "unreasonable" or "extreme" cognitions or expectations about motherhood. Women may experience very rigid ideas about what they "should" be doing and feeling during pregnancy and as a mother. These ideas sometimes do not match their experiences, which can contribute to negative feelings about themselves. For example, a pregnant woman who is depressed may feel guilty for not being excited and "glowing" while she is pregnant. Therefore, it is important to explore these ideas with the client to see how her thoughts patterns help or hurt her and to explore new thoughts that better match her experiences.

Selection of Module

"I can't stop thinking about what a failure I am. When I think about going out with my parents or going to an event, it's all I think about."

Choose this module when the woman states that she believes her primary problems with mood are based on her thinking patterns and/or recurring thoughts (such as "I am a failure/disappointment/unfit mom") and she wants this to be a target of therapy. Choose this module if unhelpful thoughts seem to be distressing her or getting in the way of engaging in positive activities or completing other modules.

Key Principles

- How we interpret events in our world helps to shape our mood and behavior.
- All people have unique patterns of thoughts, and they often help us make sense of situations and organize information.
- Beliefs become counterproductive when they are extreme, rigidly held, or no longer fit the situation the client is in.
- Cognitive restructuring helps clients "loosen up" rigid thinking or beliefs that are not useful for the client's current situation.

Goals and Strategies for Module

The purpose of Cognitive Restructuring is to:

1. Determine the relationship between thoughts, mood, and behavior
2. Change thoughts in an effort to improve mood and encourage more appropriately active behavior.

Overview of Goals, Interventions, and Handouts

Goals		Interventions	Handouts
1. Identify Thought Patterns and link to mood	A	Introduce the concept of Automatic Thoughts	
	B	Explore her thoughts around pregnancy, parenting, and motherhood	
	C	Follow Emotion	
	D	Guided Discovery	
	E	Thought Recording	**Events/Thoughts Log**
	F	Imagery	
	G	Role Play	
2. Modify Unhelpful Thought Patterns	A	Identify Unhelpful Thought Patterns	
	B	Test Automatic Thoughts	
	C	Brainstorm Alternatives	
	D	**Develop new, more accurate and helpful thoughts**	

NOTE: Not all techniques will be used for all clients, and some women may need more time than others to complete each goal. Remember to keep treatment individualized and flexible.

Goal 1. Identify Thought Patterns and Link to Mood

Clients are asked to become active observers of the impact of their thoughts on their mood. This is accomplished both with the event/thought/mood tracking form, and informally through client observations of the links between thoughts and mood.

Intervention 1A: Introduce the Concept of an Automatic Thought

"One of our goals is to learn more about what's going on in your thoughts. Depression can affect how we think and sometimes it can make our thinking not quite accurate by really focusing on the negatives. Our goal is not simply to think more positively, but to try to think more accurately."

Automatic thoughts are the thoughts that pop into our head throughout the day. They are our "internal dialogue." We may not even be aware of them all the time, but they impact our mood.

Elicit some automatic thoughts from client to help illustrate the concept of automatic thoughts. Ask her if she is aware of any automatic thoughts in her life. Continue to normalize that everyone has thoughts and it is not about "thinking wrong", but rather it is useful to evaluate if these thoughts are helpful or unhelpful.

Suggestion: When exploring thought patterns, it is especially helpful to be focused by sticking to a topic and going for depth within that topic. Focusing on recent events can help in being concrete and specific. Remember to be empathetic and non-judgmental. This is not a process of discovering what the therapist thinks is unhelpful, but a process for the client to explore with the therapist her thought patterns.

"Sometimes people who are depressed think, 'I am a horrible person', and that is a depressing thought. When you're depressed, what goes through your mind? How does that impact you?"

Intervention 1B: Explore her thoughts about pregnancy, parenting, and motherhood

The perinatal period is one of significant transition. Women often find themselves faced with new roles (i.e., "mother") and new responsibilities (e.g., juggling the demands of a new infant with the care of other children). There are considerable expectations - personal, familial and societal - associated with motherhood.

A few questions may be useful in understanding views of parenting and their origin:

-What are your thoughts/expectations of yourself as a mother?

-What do you think has influenced your expectations of motherhood? Society? Friends? Family?

-How do you feel about yourself as a parent? How do these beliefs/expectations work for you? How might they harm you?

♀ **Behind automatic thoughts are core beliefs, ideas that govern our behavior and help us make sense of our environment and experiences. For example, a new mother may think, "I am a failure" when her baby won't stop crying. Tied to the automatic thought of "I am a failure" is the belief that "Good mothers can soothe their babies immediately." Often beliefs around parenting and pregnancy will come up when discussing automatic thoughts with a client.**

Common beliefs to explore:

Self-Care Beliefs

Client: "Right now it's hard to say, 'Mom can you take him for five minutes so I can go to the store or whatever.' I think that…women want to do it by themselves. They don't want to ask for help."

Therapist: "What would it mean if you asked for help?"

P: "That I wasn't capable of doing it. It feels like I don't deserve the help."

Expectations About Motherhood

[A mother having difficulty breastfeeding] "… you feel like the dad that says you are not making enough money for the family. You're not able to support your baby with you are supposedly… the natural thing of breastfeeding. You are not able to give that to her and able to support her on your own. You feel inadequate."

Therapist response: "It sounds like you think that you are a real failure and that you have to breastfeed to be a good mom."

Guilt About Mothering

"usually....they ....say that carrying the baby makes them smarter, you should be interacting with your baby when they are awake and playing with them and doing things. …So, when he is awake, I want to interact with him. But sometimes you can't always do that."

Guilt About Negative Emotions

"…you are the luckiest person in the world to have such a naturally beautiful, perfect, ten toes, ten finger [baby]. And you feel guilty because she is crying and you are getting upset."

Therapist Suggestion: How do I know what thought to focus on in a session?

Questions to consider:

- How strongly does the client believe in the thoughts (on a scale of 1 to 100)?
- How often does the thought occur?
- Is the thought linked to her depressed mood? If so, how strong is the emotional reaction (on a scale of 1 to 100)?
- Is the thought linked to the client's goals for therapy?

Intervention 1C: Follow emotion

Typically emotional situations are loaded with accompanying thoughts. If a client brings up something that appears to result in an emotional shift during session, it is a good idea to skillfully and gently question the client about her thoughts.

Intervention 1D: Guided Discovery

In asking clients about specific situations that cause them trouble or pain, it is useful to get concrete. Ask what happened. Ask how the client felt. Ask the client how she felt about herself. Ask her what she thought the situation might mean for or about her, or what her concerns were in that situation. This line of questioning often yields automatic thoughts.

Intervention 1E: Thought Recording

The column technique. Thought records are a backbone to CBT. In the 2-column technique, client records thoughts and events. In the 3-column technique (easy to implement if client

has already been doing BA column approach), client records events, thoughts, and emotions. See appendix for examples.

Intervention 1F: Imagery

Ask client to imagine a situation that was emotional in nature. To help client recall situation, ask for specific details of the event, for instance, the sights, smells and sounds accompanying the memory. Use questions throughout the imagery exercise to help client think about automatic thoughts.

Intervention 1G: Role Play

If client's depression involves an interpersonal problem, it may be useful to use role plays to elicit automatic thoughts. The therapist takes on the role of the person in the client's life. The dyad act out a situation that is emotional for the client (e.g., a recent negative event). Use the role play to elicit thoughts.

Case example: Mother of 6-week old baby

Client (describing negative feelings toward baby and motherhood): "I want out. I don't want this. I feel like I'm suffocating."

Therapist: "What goes through your mind when you voice those feelings?"

Client: "That I shouldn't feel this way. I'm failing."

Therapist: "Did you have any more thoughts about these feelings?"

Client: "More thoughts? Yeah. That I'm a bad mother. I can't and shouldn't be doing this and now we're (baby and child) both in trouble."

Therapist: "So it sounds like a couple of the thoughts that often come into your mind is that you're a failure as a mother and that you shouldn't feel suffocated. Is that right?"

Case example: Pregnant woman desiring more help from partner

Therapist: (summarizing woman's description of frustration and anger towards partner's level of help): "So, let me see if I have this right. Because you're pregnant, you're having a difficult time getting things done around the house. You'd like your partner to help you more, but that doesn't seem to be happening in the ways you'd like it to. Is that right?"

Client: "Yes! It's driving me nuts! I don't know what to do."

Therapist: "And when you feel that way, what thoughts go through your head?"

Client: "He doesn't care. He just doesn't care." (starts to cry)

Therapist (noting intensity of emotion): "And what does that mean to you, if he doesn't care?"

Client: "That there's no hope. What can I do? It's not like things are going to get better. I'm going to have this baby, and no help. What's the point of even trying?"

Therapist: "When you have those thoughts, how do you feel?"

Client: "Awful. Really down."

Therapist: "What do you do when you're feeling like that?"

Client: "I just want to give up. Usually, I just go to sleep."

Therapist: "It seems like one of the thoughts that comes into your mind is that your partner just doesn't care about you. Is that right?"

Goal 2: Modifying Unhelpful Thinking Patterns

Remember that the goal is not to convey that the client's thinking is wrong or is the cause of her depression. After looking at the links between mood and thoughts, going deeper into her style and pattern of thoughts helps to potentially change thoughts that are unhelpful.

Intervention 2A: Identify Unhelpful Thought Patterns

Once you and the client have identified some unhelpful thoughts and the link between these thoughts and her mood, it is useful to also identify commonly occurring themes in the client's thinking. People often have similar ways of thinking. Discovering themes in their thinking can be useful a way for clients to identify unhelpful ways of thinking. The following is a list of common unhelpful thinking patterns that are particularly evident when a client is depressed.

Common Unhelpful Thinking Patterns

Describing all of these types of patterns may be overwhelming or distracting to a client. Instead, these are best used by the therapist to introduce a concept, such as, "Depression often limits our perception to only be able to see the negative events. Sometimes we look at this black/white type of thinking as unhelpful. Do you see this happening in your life?"

1.) **All-or-nothing thinking**: Seeing things in black and white, extreme categories. "If my performance falls short of perfect, I am a total failure."

2.) **Overgeneralization**: Viewing a single negative event as a never-ending pattern of defeat. "I went to the grocery store and was unable to stop my baby from crying. I am so embarrassed. I am a terrible mother- I can never soothe my baby."

3.) **Mental filter**: Picking out a single negative detail and dwelling on it exclusively so that the vision of all reality becomes darkened, like the drop of ink that discolors the entire beaker of water. An example is that 10 people come to visit a client after she gives birth. While the visits went well, the client only remembers one uncomfortable moment when someone commented on how she was feeding the baby. She then thinks that "no one thinks I am a good mother", or

is too embarrassed to have friends over again, or think that the visits went horribly.

4.) **Disqualifying the positive**: Rejecting positive experiences by insisting they "don't count" for some reason or other. Maintaining a negative belief that is contradicted by everyday experiences. For example, the client goes to the nurse for her postpartum visit and the nurse states that the baby is healthy and she's doing a great job. The client thinks that the nurse is "just saying that because she has to." She disqualifies any praise from friends or family as "they are just trying to be nice" or "I am just doing the basic care—I don't deserve their praise."

5.) **Jumping to conclusions**: Making a negative interpretation even though there are no definite facts that convincingly support the conclusion. Arbitrarily concluding that someone is reacting negatively to you and don't bother to check it out. The client thinks her friend thinks that she's boring because she's pregnant, even though her friend hasn't voiced this feeling. The client stops calling her friend and feels alone.

6.) **The Fortune Teller Error**: You anticipate that things will turn out badly and feel convinced that your prediction is an already-established fact. A client who is pregnant thinks "I know I won't be able to breastfeed the right way and shouldn't even try" even though there is no indication from her medical providers that this is the case.

7.) **Magnification (catastrophizing) or minimization**: You exaggerate the importance of things (such as an error you make), or you inappropriately shrink things until they appear tiny. "I

can't even get to my OB appointment on time—how will I be able to raise a child?"

8.) **Should statements**: You try to motivate yourself with shoulds and shouldn'ts, as if you had to be whipped and punished before you could be expected to do anything. "Musts" and "oughts" are also offenders. The emotional consequence is guilt. When you direct should statements toward others, you feel anger, frustration, and resentment. "I should be married before I have a child." "I should take care of the baby before taking care of myself."

Intervention 2B: Test Automatic Thoughts

At this point you have identified with the client a specific thought to explore. It is important to sum up that thought and to check-in with the client to affirm that is the thought for her and to ask permission to look further at this thought. For example, stating "From what you've told me, the thought that comes up for you is that "I am a terrible mom." Can we talk more about this thought?" Then follow with an exploration of that thought, such as "Can we talk more about being a mom?" and "What's happened in your life to make you feel this way?"

Remember, the goal is to focus on broadening or loosening the way the client is thinking, rather than pointing out the woman's thinking is wrong. Your goal will be to help the client start to think in different, or broader, ways.

"When you think this thought, how do you feel?"

"What makes you think this is true?"

"Tell me more about your life experiences around ___."

"Can we talk a little more about this thought and talk about all sides of it?"

[After discussing new thoughts] "What is it like to talk about these other ways of looking at it? [Discuss immediate impact on mood—how does she feel talking about positive experiences?

Here are questions for you, the therapist, to keep in mind:

- How is this thought affecting the client?
- What current experiences and past experiences have led to this thought?

Keep in mind, also, these process steps for guidance:

- Examine how this thought is affecting the client;
- Examine evidence for thought and against thought—remember that this is not simply about encouraging "positive thinking" but to loosen up the client's thinking and find more accurate thoughts;
- Explore with client alternate ways of viewing and new potential thoughts.

The goal of the questions is to help the client open her mind to possibilities. Ask questions that might open up different perspectives on the situation or possibilities for change.

Specific Ways to Address Unhelpful Thinking Patterns:

1.) **All-or-nothing thinking, Overgeneralization, Mental filter, disqualifying the positive, Magnification (catastrophizing) or minimization**:

Point out that one of the effects/symptoms of depression is that some of the more positive experiences in our lives tend to be filtered out through depressive thinking. Our mindset actually changes our perception and often narrows our focus so

that we may not see the whole picture. For example, plants find it more difficult to take in nutrients if the soil gets hard. Depression can be like that—positive, meaningful events can happen in our lives and we may have a more difficult time taking them in than the negatives. A thought log may also help in helping the client challenge the extreme thinking.

2.) **Jumping to conclusions, Fortune Teller Error, Catastrophizing**:

One intervention is testing out to what extent those ideas were spoken and to what extent did they come from the client's thoughts. Gather more detailed information about exactly how the thoughts were formed.

Also, test out predictions. Explore with the client her record of predicting events and the effects:

T: "It sounds like you're predicting that there will be trouble?" (Client nods) "Have you predicted trouble before?" (Client still nodding) "What kind of things have you predicted that came true?

P: [Shares experiences]

T: "It sounds like you've been doing some predicting and sometimes your predictions are true. Can we look at all sides? Can you tell me about times when they haven't come true?"

P:[Shares experiences]

T: "From what you've told me, there are times when you are right and times when you have been wrong when you've predicted events. You're telling me you aren't 100% accurate when you predict things. When you do predict that things will go badly, how does it impact you?"

P: “I tend to get upset—like right now, with my worries about the delivery, I just sit at home and cry about it. Sometimes I can’t sleep because I know it will go badly.”

“How accurate have you been in predicting events? To what extent do these predictions of what others will think or events happening prevent you from doing what you want or were hoping to do? To what extent do they impact your mood? How helpful have these predictions been to you?”

Specifically for Catastrophizing, ask “What would be the worst the thing that would happen?” Then, gather step-by step ideas about what would happen. Explore the client’s perception of how likely is it that the worst that could happen will happen. Together, go over evidence for and against the event happening.

3.) **Should statements**:

Think about where the “shoulds” came from—is there something specific to motherhood or pregnancy—what kind of messages do you get from others that reinforce these ideas? Are these ideas helpful or unhelpful? To what extent do you feel like these are reasonable expectations of yourself? To what extent do you feel they help or harm you? If you had a friend telling you about these expectations, what would you say? Would you agree or would you say that she was being hard on herself?

♀ **WHEN EXPLORING "SHOULD" STATEMENTS, OFTEN THESE IDEAS ARE TIED TO BELIEFS ABOUT PREGNANCY AND MOTHERHOOD. IT MAY BE HELPFUL FOR THE CLIENT TO SEE THE WIDE VARIETY OF EXPERIENCES PARENTS HAVE AND TO WORK ON CREATING A NEW THOUGHT/BELIEF THAT MORE ACCURATELY DESCRIBES HER LIFE.**

Normalization about the tricky nature of motherhood is often important. Women who are depressed frequently assume that they might be the only ones feeling negatively about motherhood. Such ideas may ultimately serve to alienate women from other parents. Thus, it may be appropriate to brainstorm ways to get normalizing information from other parents with the client.

It is also helpful to counter negative expectations by providing mothers with psycho-education about the nature of parent-child interactions. Although much of infant's personalities may be malleable, current research also suggests that infants are born with temperaments. In essence, every child is different, and what works with one child might not work with another. This is important information for both new moms, who might compare their children to other children, and to moms of multiple children, who may find that their new child is somewhat of a mystery. Thus, direct comparisons with other children may not be the only or best ways to counter negative beliers.

In brainstorming and evaluating strategies to cope with parenting struggles, it is important to remind that client that the best strategies are those that work best for both child and mom (e.g., although baby may go right back to sleep after being rocked by an adult, this may not work well for the parent if the child is waking multiple times in the night and this is the only way the child can fall back to sleep). When examining beliefs, it

can also be helpful to look at the costs and benefits of believing and the affects of the belief on the client's life goals.

Intervention 2C: Brainstorm Alternatives

1.) Ask the client about the helpfulness or unhelpfulness of the thought. Explore the impact it has on her mood.

For example (to a client who noted she had thoughts that she was a bad mom because she didn't feel as if she was attached to her child as she should be):

Therapist: "When you think, 'I'm just not attached. I'm a bad mom,' how does that thought end up working for you?"

Client: "Not well. I just don't feel like doing much with my baby. It's as if even being with her reminds me that I'm not right."

T: "And what do you do when you're thinking those thoughts?"

P: "I just kind of let the baby be. I mean, I don't hold her. Don't play with her."

T: "How is that for you?"

P: "It just makes it worse! Then I really feel like a bad mom, you know?"

T: "So, that thought isn't helping you with your desire to feel closer to your daughter?"

P: "No. No, not at all."

2.) Be open to other possibilities. Ask the client if there might be other ways of thinking about the situation, if others might

think differently about the situation were they in it, or what advice/perspective she might offer to a friend in her situation. It is sometimes useful to find and ask trusted others what they might do, or how they managed, in a similar situation. This can be particularly important for pregnant and postnatal women, who might assume that they are alone in feeling frustrated and sad. Getting other women's perspective on handling the ups and downs of motherhood can be both normalizing and perspective building. It may be helpful for women to use professional, online, community, and familial resources.

3.) Think like your old self. This technique builds on the resilience and strengths of the client. It may be useful to ask the client what she would have thought when she wasn't depressed. Or, if the client maintains good functioning in some circumstances, ask her to think like the "healthy" her.

4.) Brainstorm ideas and different perspectives! Be creative and open—give permission for both you and the client to throw out new ideas, thoughts and perspectives without judgment or without the client censoring herself.

What not to do:

(1) Be overly directive: e.g., ask: "have you thought about it this way?"

(2) Ask leading questions – let the client generate her own responses and solutions. Your goal is to provide gentle questions that help her explore alternatives.

(3) Ask questions that assume you already know the answer. This can be a frustrating experience for the client. Stay close to her experiences, and allow her to generate different responses. At the same time, do not let the client flounder if she's struggling. Gently take some of the different questioning

approaches mentioned above. If these do not yield responses, it is sometimes appropriate to offer some potential alternatives. If you do that, be sure to follow these guidelines: do so if all other approaches fail, offer alternatives tentatively and check in with the client to see if they might fit (e.g., for a woman struggling with catastrophizing thoughts "sometimes people who strongly believe their thoughts can have a hard time seeing alternatives. That's understandable. Other women who have struggled with these kinds of thoughts have sometimes found that their predictions weren't as certain and as negative as they thought they might be, and found that talking to others helped them to believe that. Does that sound like one possible other way of thinking about it for you?")

Intervention 2D: Develop new, more accurate and helpful thoughts

Explore the thought(s) that she has identified as unhelpful and the alternatives she has suggested. Work with her to find a new thought that is affirming, helpful, and empowering. Offer patience and empathy that change is difficult. Use the process as a discovery process—

"What do you think about trying out this new thought for a week? We can use this as an opportunity to learn more about other automatic thoughts you have. There is no "right" or "wrong" way of working on modifying our thoughts. We can gather important information about your life through the process. How does this sound?"

"Based on what you've told me, this thought ("I am a complete failure") is not altogether helpful or effective because it stops you from doing things that you really enjoy, like going to church and hanging out with your friends. What do you think is

a different thought that you could have that would be more helpful?"

"Depression often encourages more extreme, black and white thinking. Based on what you told me, your thoughts aren't matching your experiences. What is a new thought that reflects your experiences?"

Example Session Structure

1. Debrief client's weekly thoughts, activities and mood. Draw links between thoughts, mood and context.

2. Work on cognitive restructuring, including devising alternative thoughts, role plays, and behavioral experiments

3. Assess progress towards client's identified goals.

Therapist Note:

Being a sensitive CBT therapist – applying collaborative empiricism.

Depressed individuals can be alert to feedback that they are "wrong" in the way they think. This is where a collaborative empirical approach can be helpful. It is important to be sensitive and thoughtful about the difficulties depressed clients have had in their lives.

Instead of the therapist pointing out how the client is "irrational," it is helpful to (a) discuss how thoughts and moods are connected, and (b) talk about how thoughts may or may not be working for client in her current circumstances (c) use neutral, collaborative approaches to counter unhelpful thinking

(e.g., if client believes that she will not be liked if she voices her opinions, she might first observe how others respond to people who voice their opinions. She may then try out experimental situations of increasing difficulty. For example, she may start by asking for something small from an acquaintance and see if this results in rejecting behavior.)

Summary

Therapists should attend to:

- Personalized care of exploring helpful and unhelpful thoughts for each client

- Thoughts that are inconsistent and consistent with the client's personal goals/desires and experiences

- Signs that the client is feeling blamed or is feeling as though she is "thinking wrong"

Case Examples:

Description of the client

Information of Assessment:

First Cognitive Restructuring session:

Sample dialogue

Transcribe sample session and Create one simple, "goes well" session

Insert frames with "coding" the techniques and reference information

Insert symbols by "coding" session

Module

5

Optional Module:

Module 5: Pre-delivery and Postpartum Assessments

Overview

This module focuses on the specific needs before delivery and following delivery. A postpartum assessment is included to be used during the first session following the delivery. This module contains educational materials about the changes associated with the pregnancy and postpartum time periods. The handouts and information are designed to be given to clients with discretion.

***** Before giving any handouts, it is very important to stress that every woman's experience is different and to validate the range of experiences unique to each client. Affirm that due to the variety of events and concerns, there is not one way (one right way or perfect way) to go through pregnancy, delivery, and parenthood. *****

Background Information

This treatment is designed to be tailored to the needs of a variety of women in the perinatal time period. Women often feel a lot of pressure, stress, worry, and uncertainty around the delivery process and parenting.

Often, materials for pregnant and postpartum women provide a limited view on how to handle pregnancy, go through delivery, and prepare for motherhood. Instead of presenting only one way or a definition of the “right” way to handle these transitions, it is important to offer multiple possibilities, various methods of coping, and options for the client to use to make decisions for herself.

Selection of Module

This module is especially helpful to use as the client approaches her delivery date and prepares for labor and delivery. Select this module to discuss expectations around pre and post delivery time periods. This is module includes a postpartum assessment that can be used after the delivery process.

For women who are expressing a tremendous amount of worries, fears, and thoughts about concerns (especially around pregnancy, possible miscarriage, delivery, and motherhood), refer to Module 3 concerning Cognitive Therapy.

***** Use the materials as needed and give them to the client with the caveat that she can use what makes***

sense to her and disregard the rest. Allow her to decide what is useful to her circumstances. *

Key Principles

Information is not meant to judge the client or to show her the “right” way to handle the changes associated with pregnancy and the postpartum time period. Allow the client to be in touch with her body and her baby to make decisions that are best for her situation.

Discuss various possible outcomes and concerns with delivery, pregnancy, and after birth. This discussion can be used as empowering conversation to break through unrealistic expectations and to develop and affirm client’s decision-making capabilities and skills.

Allow the client to explore other sources of information and to pick and chose what is most important to her.

Conduct a postpartum assessment to see if her needs have changed, as well as to give the client space to discuss the birth experience.

Goals and Techniques for Module

Goals		Techniques	Supplements
1. Identify pregnancy expectations	A	Discuss expectations for motherhood	
	B	Discuss impact of others' messages about pregnancy on current mood	
2. Prepare for birth and identify coping strategies	A	Discuss birth plan and alternative scenarios	
	B	Create coping cards around birth plan and challenges	**Sample Coping Cards**
3. Identify community resources and birth information	A	Explore client's resources for available information	**Delivery Preparation List**
	B	Assist with finding additional information as needed	**Postpartum and Recovery Handout**
4. Evaluate new needs for the postpartum time period	**A**	**Postpartum Assessment**	**Assessment Guide**
5. Psycho-education for the postpartum period	**A**	**Role of sleep**	
	B	**Local resources**	

1A. Discuss with client her expectations of motherhood and messages she has received about pregnancy, delivery, and parenting. What does she feel she has been told is the "right" way? How helpful and unhelpful are these messages? What are her experiences?

1B. What impact do these expectations have on her mood? Explore how these make her feel.

2A. Discuss possible birth scenarios and include conversation around expectations, possible pitfalls, and problem solving techniques and preparation. Explore

reasons for one specific type of delivery—is it the client's choice and real desire? Or is it coming from pressure and idea that this type is the "perfect" or "should be used" method?

"What expectations do you have of the birth experience?"

"What would you want to happen if your doctor suggests an alternative method of delivery (for example, a caesarean)?"

"How do you feel about the different methods of delivery?"

"Do you have specific questions/concerns about labor and delivery? Would you like to create a list of questions together to take to your healthcare provider? Do you wish to role play discussing this with your healthcare provider?"

"Where do you go for information on pregnancy, delivery, and parenting?"

"What type of items do you need to prepare for the baby?"

2B. Discuss the multiple possibilities of events and concerns that can arise during pregnancy, during birth, and after delivery. Affirm her autonomy and ability to make decisions. Plan and discuss different scenarios. If she is interested, create coping cards. They can include possible action plans for each scenario. During and after, validate her decision-making abilities, strengths, and available resources.

If she feels as though she will be a failure if she does not follow through with her birth plan or expectations, discuss where those ideas of failure are coming from, and to what expectation she is comparing herself. Validate that labor and delivery (as well as pregnancy and parenting) are not predictable and that there is not one right way. Affirm that she can decide which way is best for her situation, and it may change as the situation changes.

3A. Ask the client who she can contact in the community for more information about preparing for birth and gathering resources for the new baby. Explore various avenues for information seeking; other women who have gone through delivery, online support, nurses/doctor, books, and classes. *(The therapist can help with this process by collecting information about community resources and distribute information.)*

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4A. Postpartum Assessment

Assessment areas:

1. Give the client space to share her birth experience/story. Ask how her labor and delivery process went—did it match her expectations? How is she recovering?
2. Inquire into her current sleep needs. How much sleep is she currently getting? Provide psycho-education about the role of sleep and mood, as well as ways to obtain sleep during this transition time.
3. Discuss the support she is receiving from her partner and/or other signigificant others. How is she feeling? What kinds of support is she receiving? Not receiving? From family? Friends?
4. Inquire into her difficulties with the new baby.
5. Inquire into her difficulties with her other children. How are they adjusting to the newborn? How is she feeling about having another child?
6. Stress from financial difficulties, housing troubles, job stress, resource needs, etc.
7. How is her physical health? What medical issues, pain, and physical discomfort is she experiencing?
8. Difficulties with transitioning to having a new child (this may include feelings of loss of independence/control, difficulties with feeling important/valued in new role, etc.)

Relapse Prevention and Termination

"If I had to sum up what has been most helpful from this treatment, it would be learning how to talk to others about how I am feeling and working towards getting my needs met, which means action on my part. I feel like I have a better process of going about dealing with symptoms of my depression."

Relapse prevention is based on the idea that throughout therapy, the client will be picking up skills to use outside of her sessions and to continue to use after the treatment is finished. By having additional skills and personal insight, she can hopefully prevent future depressive episodes from worsening and provide alleviation of her symptoms. It is helpful to discuss the skills that she is obtaining throughout the therapy, as well as summarize them at the end of the treatment. This process provides hope for the future and can be an

empowering process that gives her a sense of control and power around handling her symptoms.

Background Information

Therapist Sample Script:

"Remember when we discussed how sleep often makes you feel worse and we looked at patterns? It can be helpful to do so periodically to keep an eye on what is helpful and unhelpful in terms of your mood."

Selection of Module

Use this module during the last 1-2 sessions to wrap up and summarize the skills the client has worked on during the sessions. Also, it made be used if there is going to be a long break between sessions in order to remind the client of the skills she can use during that break.

Relapse prevention is often subtle and can be used in any session to re-iterate previously discussed skills.

Key Principles

Stay focused on her strengths.

Goals and Strategies for Module

"What have you done in the past that has been helpful?"

Create a Plan of Care:

For example, a mother is currently activated because her infant often cries and keeps her busy. The therapist worked with her to explore what will activate her in the future. First, she talked with the client about the pattern of how the baby motivates her as the baby is an immediate and pressing need. Then, she explores with the mother how she can help herself in the near future with staying active and creating a plan for self-care.

"In 18 months when your child is more independent, what will motivate you?"

"What type of plan could we create that would help you stay motivated and activated in the coming months?"

"What else can mimic the effect that the baby has?"

It may be helpful to create a plan based on the depressive symptoms the mom feels. For example, when her mood reaches a certain level (such as a 2 on a scale of 1 to 10), she can use certain behavioural activation and cognitive strategies. She can decide the point at which she will reach out for help and work on a plan of communicating with others around how and when to interfere and help her. For example, she may have a conversation with her partner around cues that signal that she is getting depressed and talk about how to provide her with help.

Common Supervision Questions

This treatment is focused on addressing each client with flexibility and individual attention. Therefore, it is expected that therapists may face multiple issues that aren't necessarily addressed in each module. Having a clinical supervisor to listen to sessions and provide feedback and guidance is recommended. Included in this section are answers to questions that have arisen in the pilot of this treatment.

The first list of questions and answers are general treatment questions. Following are questions specifically geared for each module.

1. How do I know whether I'm really doing the intervention or not?

One thing to keep in mind is that there are many different ways to achieve the same goal in therapy. Each therapist has a particular style, and each client responds to interventions differently. This manual describes "goals" for each module, with a set of suggested techniques that you can use to achieve these goals. However, you don't have to use every technique in order to achieve the goal. Your best guide is to determine if the

session made progress toward the goal. If so, you are on the right track. Use the techniques as guides, not as mandates, for how to respond to a client's needs. Perhaps a slight rewording? "CBT is a flexible treatment that is client driven. At the beginning of treatment, you and the client will work together to come up with a case formulation. This includes a conceptualization of her depression and goals for her treatment. This formulation should guide your treatment. The techniques included in the manual are tools to use towards accomplishing the client's goals. As long as you always keep the formulation in mind, and work towards achieving the client's goals, then you are doing the intervention.

2. How do I know when I'm finished covering a topic or module?

Although this treatment uses a manual, the amount of time you may spend on any one module can vary greatly. Use the overall module goals as your guide. For example, the first goal of behavioral activation is to identify links between mood and behaviors. This can take anywhere from part of a session (e.g., your client knows that she feels better when she exercises, and that she would benefit from doing it more often) to several sessions (e.g., your client hasn't expressed that she's sure if sleeping during the day is helpful and restful or if it contributes to her overall feelings of uselessness). The second goal, building behavioral alternatives, may also take one to several sessions to discuss. Is the client on her way to becoming more active? Has she taken steps during the week to indicate that she is working toward new behavioral alternatives? Are barriers arising that deserve more attention in the session? Is there another pressing issue that is best addressed by another module? These types of questions can help determine if it is time to move to another topic area.

3. Sometimes my client seems to be talking about irrelevant things. How do I know whether it is useful discussion or not, and if not, how do I redirect the conversation?

A good question to ask yourself is, how is what my client is talking about related to her overall treatment goals well-being and mood? For example, is she describing in detail how hopeless a situation has become, or how little support she is getting from others? If the answer is not clear to you, try asking her. Simply saying, "I hear how pressing this issue is for you. At the same time, I want to be sure that we are spending this time on what you want to talk about. We'd discussed focusing on "xyz" I'm wondering if this fits with that? Or if you'd like to talk about this issue for a bit and then move to focusing back on "xyz." How do you think what we're talking about relates to your mood/depression?" may help you to see the connection or may lead her to change the topic.

One way to keep a focus is to reinforce (through questions or reflections) on the aspects of her conversation that appear most relevant to mood. For example, she is talking at length about how her partner is no help to her at all and how terrible he is. You might respond with "if it's okay, I'd like to stop for just a second because I think you hit on something very important when you said you felt like you were completely alone. Can you tell me more about that feeling?"

4. This problem seems like it could be Behavioral, or Cognitive, or Interpersonal. How do I know where to start?

This is a very common issue, because most of the issues covered in therapy could be viewed and addressed through any

of these three perspectives. In these cases, the best option is the one that fits best with how the client sees the problem or the option that you think has the best likelihood of success with her. For example, a woman may have the thought, "I'm lazy and unattractive" and also have withdrawn from her previous activities. You could address the activities through behavioral activation, or address the thoughts that prevent her from engaging in the activities. When in doubt, behavioral activation is often the easiest and most powerful place to begin, as women can find great benefits from making steps toward being more active.

5. What did I actually do in that session?

Sometimes it can be hard to summarize what we did in a session. Looking back, you can consider two elements that are important for treatment: What did I do that made the client feel heard, respected, hopeful, etc.? and What did I do that addressed the client's depressive symptoms? Some sessions will have more of one element than the other, and in some sessions the intervention is more clearly defined than in others. Think broadly about the areas of cognitive, behavioral, or interpersonal change. Did you explore the link between mood and those areas? Did you discuss problems or barriers related to change in those topic areas? Interventions may not look just as they appear in the manual, but still can be effective. Also, refer to CTS – deepening understanding (e.g., through summarization), discussing strategies for change, applying strategies for change (even is they don't follow the text-book version), exploring options, "loosening up" thoughts about a situation, discussing specific thoughts or behaviors – all are on-target activities.

6. Sometimes I wonder if I'm being too directive in our sessions, but I also worry about being so flexible that we don't end up doing any intervention. What should I do?

This is a tough balance to achieve, and most therapists struggle with this regardless of the intervention. If the client shows resistance to an intervention, take a step back and spend more time understanding the problem from her perspective. If you find yourself feeling unfocused during the session, ask yourself what seems to be most related to the client's mood right now, and consider the possible techniques that would address this issue. If you find that it is difficult to stay on one topic, you might mention to the client something like, "We have such a short time for our meetings together, this treatment will be most useful if we are focusing on areas that are most related to your mood. Of the things we've talked about today, what do you think is the best place for us to focus on?"

7. How do I know if this is working?

The main goal of our treatment is to reduce symptoms of depression and improve the client's daily functioning. Use the EPDS as a guide of the client's progress. If it is going down, treatment probably is working! If it goes up or stays the same, you may ask yourself and your client what would be more useful for her particular situation.

Another important point in judging treatment's success is whether the change will carry on after treatment ends. So, for example, if you get the sense that your client really enjoys talking with you but has made no headway in finding other social support, then treatment is unlikely to have a lasting effect without shifting focus.

8. What do I do if she is very emotional or upset by another issue?

(For example, one of her loved ones passes away during our treatment?) This can be a difficult problem. You might keep several things in mind. First, how major is the event? Will it likely last a long time and/or have a big impact on the client in relation to her goals? If so, it might be worth talking about the impact this event is having, and whether the client feels it would be better to (a) stick with the current therapy goals and stay on track for the current session, (b) stick with the current therapy goals, but spend some time on the pressing issue in session that day (if this path is chosen, try to look for themes emerging in the current event that might pertain to the client's goals) (c) change the goals of therapy to fit with the current pressing event. As a general rule, it is not a good idea to change therapy goals more than once.

9. What do I do if she asks me personal questions or makes personal attacks?

(Such as asking for a ride home, makes comments like "well, you aren't pregnant, how would you know?"). First and foremost, be genuine. Secondly, consider what the client might be expressing. For example, is she feeling upset and misunderstood, worrying about how you, as the therapist might be able to help her? In those instances, it might be helpful to say something like, "it sounds like you're worried that I don't understand what you're going through." Sometimes boundary issues are raised. Maintain your boundaries (e.g., "I know how difficult it is for you to arrange transportation to and from places, but I'm sorry, I can't provide you with a ride home.") You may need to explain the reasons behind this – for example, this might be a time to discuss the professional

boundaries you have, and/or the logistical limits you have as well (e.g., "insurance does not cover me if I transport you.")

10. How do I balance her feelings of hopelessness and providing hope?

Often it is important to provide women space to really express how they are feeling and what has been happening—to express the depth of their hopelessness and for the therapist to be present for that intense emotion. "It seems like you're really hopeless and need some space to talk about it." It is important to balance allowing space for that emotion with finding ways of moving towards hope. Using the information you have about her strengths and survival abilities is helpful in combating some of the hopelessness. The important aspect is to not rush past her emotion, but allow time for it to be expressed and then gently moving towards looking for hope.

11. My client is having that thoughts that are unhelpful, but she's also using rumination as a way of avoiding action. Therefore, we could address either the content of her thoughts (and use Cognitive Restructuring) or her behavior of excessive thinking (and use the Behavioral Activation module). Which do I do?

Module 2: Behavioral Activation Questions

Q: How do I introduce homework exercises to a very bsy and overwhelmed client?

A: It is helpful to encourage clients to think about when and how they might complete the exercise. For instance, some women may find it useful to keep a small notepad on a table next to where they feed and hold their baby. This may allow them to quickly fill out the monitoring sheet as frequently as possible. It may be useful to discuss the benefits of "in the moment" recording (more accurate and objective) versus retroactive (influenced by later mood, memory biases, lost information) approaches. Sleep deprived mothers may have a particular appreciation for the importance of in the moment recording! Stress that this is a learning process for both of you, and that there is no "wrong" way for her to do the homework. Also discuss if "homework" is a useful term or not; she may prefer "weekly goal" or "journaling."

Be aware of her literacy abilities as well as developing homework tasks that are feasible. Being flexible means customizing homework to match her abilities, needs, and goals. Completing homework can be a method of building competence. Therefore, homework should not be too daunting or too complicated.

Q: What do I do if the client did not complete the exercise from last week?

A: At times, clients will not have completed or will have partially completed their therapy exercises. These are critical moments in therapy. Previous research has demonstrated that

outside practice of therapy content in CBT is an important predictor of treatment success (). It is essential that the therapist address struggles to complete exercises in a timely fashion, while also working to uphold the collaborative spirit of CBT. Several suggestions on doing this include:

- **Do not treat incomplete exercises as failures**. It is important for the therapist to remain optimistic and to treat the incident as a therapeutic learning opportunity. Work with the client to assess factors involved in failing to complete the exercise. What barriers impacted the client? How did she cope with those barriers? What is her understanding of the exercise? What is her level of readiness to complete the exercise? An incomplete exercise may mean providing more information about the purpose of the exercise, or working with her to devise ways to get the exercise done. For example, a client who struggles with time constraints may need to learn to record mood and behavior at certain times during the day, and may devise abbreviations for commonly occurring behaviors (e.g. feed baby- fb, trying to calm baby- cb, worrying- w). It may be helpful to simply input common behavior abbreviations ine ach time slot so that she needs only to circle the relevant behavior or write in a less commonly occurring one.

- **Remember some information is better than none.** Praise the client for what she was able to get done. Attend to factors that assisted her in completing what she did do. Use the available information to try to discern some of the points listed above.

- **Be flexible.** If the client repeatedly is unable to complete the full range of the exercise, it may be useful to modify the exercise based on the client and therapist goals. For instance, if she notes that she has better and worse

moments, it may be useful to take a mood-generated approach, in which she pauses to write down moments when her mood exceeds a certain level (e.g. 7) or falls below a certain level (e.g. 3).

Q: What do I do if the client does not think she can do any other activity? What is her barriers are multiple and valid?

Q: What if the client can not come up with ideas of pleasurable activities?

A: See the handout in the appendix: "Accessible Activities". Pay particular attention to her financial and logistical restraints. (Does she have a car? Money for an activity? What can she do with an infant? In her 8th month of pregnancy?)

Module 3: Enhancing Social Support Questions, Concerns, Potential Pitfalls

Q. The client is not able to engage in interpersonal work because they cannot recount details of interactions.

A.

Q. The client cannot engage in interpersonal work because they are hopeless that they can bring about any change.

A.

Q. The client cannot engage in interpersonal work because unhelpful thoughts are interfering with communication analyses or problem solving

A.

Q. The client wants her significant other to come to the session with her. How do I handle these requests?

A.

Module 4: Cognitive Restructuring

Questions, Concerns, Pitfalls

Myth #1: Cognitive therapy tells clients their thinking is simply wrong, or irrational. This is not the case. It is important to let clients know that they learned their beliefs from their previous experiences. Sometimes their beliefs may have worked for them, but now are not (e.g., "I mean, I know I don't have to worry about it all but I try to do it all myself").

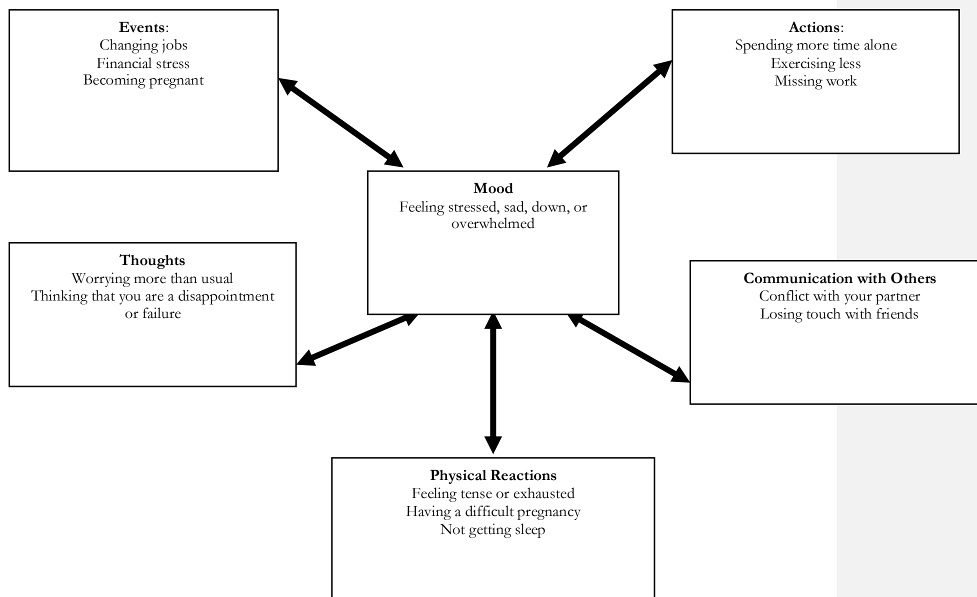
People may also have both negative and positive beliefs about themselves. When not depressed, the positive and neutral thoughts are predominate (e.g., "I'm an okay mother. I can be fun."). When depressed, negative thoughts become active and essentially take over ("I can't do this. I'm a bad mother.").

Myth #2: Cognitive therapy is the "power of positive thinking." This is not the case. Cognitive therapy helps client restructure

their current thoughts so that they are less rigid and more functional for that particular woman. (e.g., "it's 3am and the baby won't stop fussing. This is really hard, but I'll make it.")

Myth #3: Cognitive therapy is blaming. It is also important to distinguish between thoughts that are "irrational," or are not strongly supported by environmental evidence, and thoughts that are rational. This can be tricky. Depression convinces people that only the negative evidence is true. In turn, depressed individuals can be quite convincing in arguing that things are hopeless. As a therapist, it is important to gather concrete evidence about the depressed person's life to help determine whether or not a thought is irrational. For instance, if a client says she had a negative conversation with someone and that this is an example of how people are rejecting, it is important to find out exactly what was said to determine if the person was rejecting or not.

If the client's thoughts are rational, then it is not appropriate to engage in cognitive restructuring about those specific thoughts. A problem-solving, behavioral activation approach is more appropriate in those circumstances.



Events:
Changing jobs
Financial stress
Becoming pregnant
Actions:
Spending more time alone
Exercising less
Missing work
Mood
Feeling stressed, sad, down, or overwhelmed
Thoughts
Worrying more than usual
Thinking that you are a disappointment or failure
Communication with Others
Conflict with your partner
Losing touch with friends
Physical Reactions
Feeling tense or exhausted
Having a difficult pregnancy
Not getting sleep

Weekly Mood Log

Some women find that keeping a weekly log helps them to notice patterns in their moods.

Date	Mood 1—10 1 = extremely depressed/down 10 = no depression	Notes
Example: 6/5/08	4	Argued with John about money. Took a walk.
MON		
TUE		
WED		
THU		
FRI		
SAT		
SUN		

Surviving Morning Sickness

In the Morning:

- Allow yourself plenty of time to get out of bed (this may mean setting your alarm earlier than normal). It helps to get out of bed slowly as you start your day.
- You may find it helpful to keep a stash of crackers or dry cereal by the bed so you can put something in your stomach as soon as you wake up.

During the Day:

- Eat small meals throughout the day to avoid getting too full or too hungry.
- Get plenty of rest, but avoid napping right after a meal. This can make nausea worse.
- Some women become more nauseous when they are in warm places.

Suggested Meals to Eat:

- Cold foods
- Bland foods (chicken soup, broth, plain baked potato)
- Plain vegetables or fruits

Suggested Snacks to Eat:

- Lemons (eat them, suck on them, sniff them)
- Ginger (ginger ale soda, ginger tea, ginger jam on toast, ginger snaps)
- Peppermint tea
- Crackers
- Gelatin Jell-O
- Flavored popsicles
- Pretzels

Treatments & Supplements:

- Taking Vitamin B6 (50 mg) daily has been shown to help with pregnancy induced nausea. You may want to ask your doctor if this would be helpful.