Understanding the needs of women with postnatal depression


Summary
This article provides an overview of postnatal depression, including strategies to detect the disorder, suggested referral pathways and examples of evidence-based interventions. The article is aimed at health and social care professionals involved in working with women and their families during pregnancy or in the postnatal period.

Introduction
Postnatal depression is a depressive disorder that can affect women in the months after childbirth. The symptoms of postnatal depression do not differ from symptoms of depression during pregnancy or at any other time in a person’s life; the only difference is the presence of the baby and the likelihood that the woman’s thoughts, worries or difficulties focus on matters related to the infant. A meta-analysis involving 59 studies found that 13% of mothers are likely to develop a depressive disorder during the first year after childbirth, of which up to half will have postnatal depression, which is a severe form of the disorder (Cox et al 1993, O’Hara and Swain 1996). Differences in the data collection methods used in these studies can explain the range in reported prevalence rates of postnatal depression of between 10-25% (Oates 2008).

Aims and intended learning outcomes
This article aims to improve health and social care professionals’ understanding of postnatal depression, including treatment and management strategies, referral pathways, and the effect of the condition on women and their families. After reading this article and completing the time out activities you should be able to:

- Differentiate between postnatal depression and other postnatal mental disorders.
- Distinguish between mild, moderate and severe forms of postnatal depression.
- Identify evidence-based guidelines to support practice.
- Illustrate referral pathways for women with postnatal depression.
- Describe evidence-based interventions used in the treatment of postnatal depression.
- Reflect on the role of the nurse in the care of women and families affected by postnatal depression.
The term postnatal depression or postpartum depression is often used incorrectly by healthcare professionals as a global term when commonly referring to any mental disorder after childbirth (Lewis 2004). It is important to differentiate between postnatal depression and other forms of severe mental disorder that can occur in the postnatal period, as mislabelling and misdiagnosis can have serious consequences in relation to the assessment of risk and outcomes for women and their infants (Lewis 2004).

Other severe postnatal mental disorders include puerperal psychosis, which is a psychotic disorder that affects one woman in 500 births (Kendell et al 1987). The condition is characterised by a florid onset, usually within the first three months after childbirth, requiring specialist care and treatment by mental health professionals. Women diagnosed with psychotic disorders such as bipolar disorder or schizophrenia may experience more pronounced symptoms or deterioration in their mental wellbeing either during pregnancy or in the postnatal period (Kendell et al 1987, Brockington 1996, Terp and Mortensen 1998). These episodes should not be referred to as postnatal depression as these women will require specialist care and treatment relevant to their particular needs and mental disorder.

Women who have a history of depressive illness or previous postnatal depression are at greater risk of developing depression in subsequent pregnancies and after childbirth. The level of increased risk appears to be related to the severity and duration of the previous depressive episode (Elliott et al 2000). It is therefore important that women are asked early in their pregnancy about the nature of any previous mental disorder and the treatment received. This will help to ensure that the risk of recurrence of depression can be identified and the most appropriate care and treatment planned for the duration of the pregnancy, including childbirth and the postnatal period.

The pregnancy period is an opportune time to put supportive plans in place to try to reduce the risks and associated difficulties of depression. Scottish mental health legislation recommends that an individual should be offered the opportunity to develop an advance statement. This is a written statement, drawn up and signed when the person is well, which sets out how the individual would prefer to be treated (or not treated) if he or she was to become ill in the future (Scottish Executive Health Department (SEHD) 2004a). Women who are at increased risk of mental illness either during pregnancy or in the postnatal period should be offered the opportunity to prepare an advance statement. Consideration should also be given to identifying arrangements for the care of any other children in the event that the woman becomes too unwell to provide care.

Recognising postnatal depression

The National Institute for Health and Clinical Excellence (NICE) (2007) recommends that pregnant women are asked the following questions during first contact with healthcare professionals in primary care or maternity services:

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?

A third question should be considered if the woman answers ‘yes’ to either of the initial questions:

- Is this something you feel you need or want help with?

Women should be asked these questions again in the postnatal period, at around four to six weeks and at three to four months (NICE 2007).

Postnatal depression ranges from mild to severe. Healthcare professionals need to be able to differentiate between mild and severe forms of the condition, as women with more severe episodes will require referral to specialist mental health professionals for care and treatment. Women with mild forms of the disorder should receive the most appropriate intervention and treatment from the primary healthcare team, social care services, voluntary sector or through self-help media, such as reading self-help books (Williams et al 2008).

The majority of women who have postnatal depression will experience a mild to moderate form of the disorder, with only 3-5% experiencing a moderate to severe form of the condition, requiring referral to psychiatric services (O’Hara and Swain 1996). In studies conducted more than 20 years ago, it was identified that many women were not forthcoming in confiding in or seeking help and advice from healthcare professionals when they were experiencing symptoms of depression (Cox et al 1987). This may have occurred because women were concerned that they might be judged negatively in some way in relation to their parenting capacity. This may still be a concern for women today, who may fear that they will be viewed as being unable to cope and that this may result in their child being taken out of their care.

Postnatal depression can be difficult to detect as it does not present or affect every woman in the same way. In some women, anxiety, distress, and agitation may be more prominent at times than...
the depression. Others may experience diurnal variation – mood may be lowest in the morning and then pick up slightly as the day progresses into early evening. The lowering of mood may also be masked by other features such as irritability, consumption of alcohol, preoccupation with physical health, obsessional symptoms or feelings of panic (World Health Organization (WHO) 1992).

Detection can be complicated further in women who have complex needs, such as those who have drug or alcohol problems or are subjected to domestic abuse. These women are, however, at greater risk of postnatal depression and suicide (Lewis 2007). Close multidisciplinary and multi-agency care should be continued through pregnancy and into the postnatal period, even in those cases where a decision is made to place the infant into the statutory care of the local authority (Lewis 2007).

Diagnosing postnatal depression involves complex clinical judgment, which is usually undertaken by a GP or mental health specialist. However, it is important that nursing and midwifery staff and other health and social care professionals are able to identify the disorder early to ensure that women are appropriately assessed and have access to effective intervention and treatment that meets their individual needs.

Midwives, nursing staff, allied healthcare professionals and GPs are in an ideal position to detect depression in their work with women and families during pregnancy and the postnatal period. The ICD-10 Classification of Mental and Behavioural Disorders (WHO 1992) is used to classify disorders for the purpose of medical diagnosis and to differentiate between mild, moderate and severe depressive episodes. Diagnosis of postnatal depression involves complicated clinical judgement as the disorder can affect women in different ways and not everyone will experience the same symptoms (Figure 1).

**Effects of postnatal depression**

A good measure for health and social care staff to gauge severity of an episode of depression is to consider the effect of symptoms or difficulties on the woman’s level of day-to-day functioning. ‘There are often signs, in addition to medical symptoms of illness, that could indicate the presence of postnatal depression, and which may be easier initially to identify. It is important, however, to differentiate between a mental disorder and normal adjustment to the changing life circumstances associated with having a baby. For example, a woman may experience lack of sleep caring for a newborn baby as the infant will need regular feeds and nappy changes, and yet disturbed sleep and tiredness can also be a symptom of depression. Changes in weight would also be expected after childbirth, as would changes in routines and activities. A woman may also experience a degree of isolation or changes in the frequency of social contact. For example, she may have previously worked and was used to having regular contact with colleagues. A woman’s finances may also be affected by the arrival of a newborn baby. These factors can make it difficult to differentiate between clinical depression and normal adjustment to change.

Good interpersonal and assessment skills are essential to enable timely detection of postnatal depression and to demonstrate an understanding of what the woman might be going through and feeling. Often women will not be forthcoming in seeking advice or support as they might be concerned about how they will be perceived by others and, in particular, what the response of health or social care professionals might be (Cox et al 1987). Indicators that a woman requires further assessment for the presence of a depressive disorder include: poor eye contact; stooped, closed posture; flat and monotone speech; slowed speech; slowed movements; picking, scratching and wringing hands; biting nails; ‘mask-like’ facial expressions; lack of attention to appearance; difficulty making decisions; being ‘guarded’ in what they are saying; not following the conversation or ‘day dreaming’; and not responding to the infant’s cues for attention.

Other indicators might include avoidance of other people and/or certain situations; a lack of confidence; social isolation or loss of confidence in social situations; not answering the door or telephone; and non-attendance at appointments. A woman may also present with physical health complaints or worry excessively about her own or her child’s health, which may be apparent through frequent appointments with a GP or at a health clinic. Healthcare professionals need to remain vigilant for women who increase their consumption of alcohol or use of non-prescribed medications or illicit substances, as they may be using these substances to deal with or mask the symptoms they are experiencing.

It is advisable to explore any concerns the woman may have about ‘appearing to cope’, and any obsessional symptoms, such as if she has a preoccupation with housework. Extreme disorganisation of the home when it is usually...
organised and an unwillingness to accept help from others may also be indicators that the woman is experiencing symptoms of postnatal depression.

As mentioned, these factors must also be viewed in light of the context of normal adjustment to change and the additional demands of caring for a newborn baby. It is important that healthcare professionals do not make any assumptions or judgements about a person’s mental wellbeing without first undertaking assessment.

Assessment or self-report measures can be useful in supporting clinical judgement and enabling conversation around the subject of mental health and wellbeing with mothers. The Edinburgh Postnatal Depression Scale (EPDS) was developed in response to health visitors’ concerns about detection of postnatal depression (Cox et al 1987). The EPDS is a ten-item self-rated questionnaire in which women are asked to what extent they have felt or experienced particular symptoms in the previous seven days. Each item is rated 0-4 and the accumulative scores give an indication of the possible presence of postnatal depression (Cox et al 1987). The Patient Health Questionnaire-9 (PHQ-9) and the Hospital Anxiety and Depression Scale (HADS) may help in the detection and rating of symptoms of depression (NICE 2007). These tools provide

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### FIGURE 1

**Severity of postnatal depression**

<table>
<thead>
<tr>
<th>List A</th>
<th>List B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Depressed mood to a degree that is definitely abnormal for the individual, present for most of the day and almost every day, largely uninfluenced by circumstances and continuous for at least two weeks.</td>
<td>1) Reduced self-confidence and self-esteem.</td>
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<tr>
<td>2) Loss of interest or pleasure in activities that are normally enjoyable.</td>
<td>2) Reduced concentration and attention.</td>
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<tr>
<td>3) Decreased energy or increased fatigue; marked tiredness after only slight effort.</td>
<td>3) Unreasonable feelings of unworthiness or excessive and inappropriate guilt.</td>
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<td></td>
<td>4) Bleak and pessimistic view of the future.</td>
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<td></td>
<td>5) Recurrent thoughts of death or suicide, or any suicidal behaviour.</td>
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<td></td>
<td>6) Change in psychomotor activity, with agitation or retardation.</td>
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<td></td>
<td>7) Sleep disturbance of any type.</td>
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<td></td>
<td>8) Change in appetite (decrease or increase) with corresponding weight change.</td>
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</tbody>
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#### Symptoms present for two weeks or more

<table>
<thead>
<tr>
<th>Mild depressive episode</th>
<th>Moderate depressive episode</th>
<th>Severe depressive episode</th>
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<tbody>
<tr>
<td>Two of the symptoms from list A plus two or more symptoms from list B to give a total of at least four symptoms.</td>
<td>At least two of the symptoms from list A must be present as well as three or four symptoms from list B to give a total of at least five to six symptoms. A woman experiencing a moderately severe depressive episode will usually have considerable difficulty in continuing with work, social or domestic activities.</td>
<td>All three of the symptoms in list A must be present plus four or more symptoms from list B to give a total of at least seven or more symptoms. A woman experiencing a severe depressive episode will usually be considerably distressed or agitated. If retardation is a prominent feature, the person may be unwilling or unable to describe many symptoms in detail. Loss of self-esteem or feelings of uselessness or guilt are common and risk of suicide is high in particularly severe cases. It is likely that the woman will only be able to continue with work, social or domestic activities to a very limited extent.</td>
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In addition to the above symptoms, somatic symptoms may also be present, especially in severe episodes

1) Marked loss of interest or pleasure in activities that are normally pleasurable.
2) Lack of emotional reactions to events or activities that normally produce an emotional response.
3) Waking in the morning two hours or more before the usual time.
4) Depression worse in the morning.
5) Objective evidence of marked psychomotor retardation or agitation (remarked on or reported by other people).
6) Marked loss of appetite.
7) Weight loss (5% or more of body weight in the past month).
8) Marked loss of libido.

(Adapted from World Health Organization 1992)
a score that indicates possible thresholds for depressive illness. The HADS gives an indication if someone is experiencing symptoms of anxiety in addition to symptoms of depression, and asks the person to rate their wellbeing in the previous seven days (Zigmond and Snaith 1983). The PHQ-9 asks people to rate the severity of symptoms of depression experienced in the previous two weeks (Kroenke et al 2001).

Policy and legislation

Policy can be an important factor in the provision of clinical services or the care that is delivered. During the past decade several policy documents and reports published in the UK have highlighted perinatal mental health problems as a public health concern, and supported strategies for improving detection and treatment across various professional disciplines and services accessed by women either pre-conceptually, during pregnancy, childbirth or in the postnatal period (Oates 2000, Lewis and Drife 2001, Lewis 2004, 2007, SEHD 2004b, NICE 2007).

Non-pharmacological intervention

The basis of any intervention is to ensure that people are treated with respect and dignity (NHS Education Scotland 2008). The document Antenatal and Postnatal Mental Health Clinical Management and Service Guidance (NICE 2007) sets out evidence-based guidance on interventions used in the management of postnatal depression, and also outlines recommendations for service provision and how services should be organised. The majority of women affected by postnatal depression will have a mild or moderate form of the disorder and should receive appropriate care and treatment from the primary care team or through accessing self-help materials. Guided self-help (Williams et al 2008) and computerised cognitive behavioural therapy (C-CBT) approaches have been shown to be effective in some individuals (Kaltenbacher et al 2008). These resources are easy to use and the woman is able to self-assess the particular difficulties she is experiencing by answering simple questions and then reading through educational information and planning goals and ‘homework’ exercises aimed at improving how she is feeling.

Exercise has also been shown to be effective in improving postnatal depression (Armstrong and Edwards 2003, 2004). A simple approach to exercise would be to encourage a woman to go for a walk with her baby in the pram. This would also allow the woman to set herself a target of getting up and dressed and getting out of the house, even if only once or twice a week initially. If she can do this with a friend or another mother it may also help to encourage regular social contact and prevent social withdrawal.

CBT, interpersonal psychotherapy and non-directive counselling are the most effective and cost effective psychological interventions in the treatment of postnatal depression (NICE 2004). Depressive episodes are often identified during contact with public health nurses, who are in an ideal position to listen and offer support to women who have a mild to moderate form of postnatal depression. This is a brief non-directive counselling approach that has proven effective in the treatment of postnatal depression when delivered in the home environment (Holden et al 1999, Wickberg and Hwang 1996). An empathetic and non-judgmental approach should be used in conjunction with active listening and non-verbal encouragement, such as nodding the head and other prompts that show interest in what is being said. Non-directive counselling enables the woman to draw her own conclusions and make her own decisions. The counsellor uses reflection to aid this process rather than providing answers or ‘directing’ the woman.

CBT is a time-limited, structured psychological treatment. It can be delivered in modified formats such as through workbooks, computerised programmes, telephone sessions, or in formalised individual or group interventions. The woman explores her thoughts, feelings and behaviours that occur in particular situations; associations are made between these three elements, her interpretation of events and the resulting effect on mood. The woman is then taught various skills and approaches to help her find solutions to problems, and to deal with or manage situations in a way that does not have a major effect on her mood (Westbrook et al 2007, Williams et al 2008).

Interpersonal psychotherapy is a structured and time-limited psychological intervention used in the treatment of depression. It is designed to focus on social and interpersonal functioning to promote change in symptoms (Sloan et al 2009). It centres on the theory that interpersonal relationships influence the course and recurrence of illness and that by engaging in psychotherapy, the person could potentially stabilise those relationships (Klerman et al 1984). The woman...
is helped to understand recent events or situations in an interpersonal context and then to explore other options for how to handle or deal with those situations. Both CBT and interpersonal psychotherapy should be carried out by trained professionals or by those under the supervision of suitably qualified professionals.

Morrell et al (2009a, 2009b) conducted a large randomised trial of public health nurses delivering psychologically informed sessions (based on cognitive behavioural or person-centred principles) to women identified as having postnatal depression. For one hour a week for eight weeks. It was found that both these psychologically informed interventions were more clinically effective than usual care delivered by public health nurses, and that they were also cost effective.

**Antidepressant medication**

Antidepressant treatment may also be appropriate for some women with more severe forms of postnatal depression (NICE 2007). This should be discussed with the mother and, where appropriate, her partner in the context of any potential risks of taking antidepressant medications if she is breastfeeding. This treatment choice must be weighed up against the potential risk of increased severity of illness if the woman does not take the medication as indicated.

If a woman becomes so severely depressed that her level of functioning and dietary intake are significantly affected, she may not be able to breastfeed. Therefore, antidepressant treatment has to be assessed in relation to the mother’s safety and wellbeing and the benefits of breastfeeding for the baby. Most antidepressants are present in some level of concentration in breast milk when taken by a woman, but there is limited information on the potential effects of this on an infant who is being breastfed.

Certain antidepressants may be contraindicated in women who are breastfeeding. It is important that the person prescribing the medication has relevant up-to-date knowledge and expertise in the area of psychotropic drug prescribing and possible side effects, or seeks advice from pharmacists or psychiatrists. There is limited evidence available on breastfeeding and antidepressants, but generally there are two main types of antidepressants used for women who wish to breastfeed. Most, but it should be emphasised not all, selective serotonin reuptake inhibitors and tricyclic antidepressants are regarded as being the safest medications for the infant (NICE 2007). Selective serotonin reuptake inhibitors have some advantages over tricyclic antidepressants in so far as they are less likely to cause major residual physical health problems or death if the woman takes an overdose, and are also less sedating (NHS Clinical Knowledge Summaries 2010). The use of other antidepressants, such as monoamine-oxidase inhibitors, serotonin and noradrenaline reuptake inhibitors (for example, venlafaxine and duloxetine), and the newer antidepressants (for example, mirtazapine and reboxetine), are not recommended as first-line treatments for postnatal depression in women who wish to breastfeed (NHS Clinical Knowledge Summaries 2010).

In agreeing the care plan, consideration should also be given to the welfare needs of families, as the effects of postnatal depression may be far reaching (Booth et al 1998). The needs and wellbeing of children must be prioritised. Healthcare professionals should assess and, where appropriate, address the needs of the infant, other children, partner, family members and carers of a woman with a mental disorder during pregnancy and the postnatal period (NICE 2007). It is important to identify postnatal depression early to maximise opportunities to reduce any detrimental effects on the relationship between the mother and infant, and her relationships with other children and family members.

Research has shown that postnatal depression can affect the mother-infant relationship and child development (Murray and Cooper 1997, Hay et al 2001). The importance of working with the mother and infant together – as opposed to treating the mother’s depression in isolation – have been studied, highlighting the effectiveness of interventions aimed specifically at improving the mother’s mental health, mother-infant interaction and child development (NICE 2007).

**Referral pathways**

In severe cases of postnatal depression, women should receive specialist care and treatment from secondary care mental health services and, where they exist, specialist perinatal mental health services (Figure 2) (Oates 2000). A small percentage of women will require admission to mental health inpatient care. If appropriate, admission should be to a specialist mother and baby mental health unit where the woman can continue to look after her baby while receiving care and treatment. The Mental Health (Care and Treatment) (Scotland) Act 2003, which came into force in 2004, states that NHS boards in Scotland must collaborate to provide specialist inpatient services for the joint care and treatment of women with postnatal depression, and their infants where appropriate. This legislation is unique to Scotland and has been influential in helping to secure the development of specialist perinatal
If you identify a woman with or at risk of postnatal mental health problems:

- Direct to sources of self-help.
- Offer non-directive counselling during visits.
- Access supported self-help or computerised cognitive behaviour therapy (see sources of further information).
- Offer brief cognitive behavioural therapy or interpersonal psychotherapy.
- Refer to other services, for example local voluntary organisations, social care, primary care mental health services and/or local support groups.
- Refer to the woman’s GP and discuss the possible need for antidepressant medication, taking into consideration whether or not the woman is breastfeeding.

If there is evidence of mild or moderate mental health problems, discuss treatment options dependent on psychosocial needs.

- If there is no improvement after a six-week period of intervention:
  - Consider structured psychological therapy (cognitive behavioural therapy or interpersonal psychotherapy).
  - If the woman is taking antidepressants and there is no improvement after six weeks (or sooner if concerned), a combination of antidepressants and structured psychological therapy should be offered, ensuring the patient is happy to continue with drug treatment.
  - If the woman’s mental state gives cause for concern – for example increased risk of self-harm or significant impairment of day-to-day functioning – consider referral to secondary care mental health services.

If the woman has a history of non-severe mental illness that did not previously require referral to secondary care mental health services:

- If evidence of mild mental health difficulties emerges, liaise with the woman’s GP and discuss treatment options with the patient. For example:
  - Direct to sources of self-help.
  - Offer non-directive counselling during visits.
  - Access supported self-help or computerised cognitive behaviour therapy (see sources of further information).
  - Direct to other services, for example local voluntary organisations, social care, support groups and/or local wellbeing projects.

If the woman is in contact with mental health services or there is evidence of severe mental health difficulties – for example increased risk of suicide or self-harm, significant impairment of day-to-day functioning or evidence of psychotic symptoms – liaise with her GP and:

- Refer to a local perinatal mental health service if available, or a community mental health team.
- If more than six months postnatal, refer the woman to a local community mental health team.

Sources of further information and self-help materials:

- Royal College of Psychiatrists website for information leaflets on various mental health problems: www.rcpsych.ac.uk/info/index.htm
- Depression Alliance booklet on depression during and after pregnancy: www.depressionalliance.org/publications/da_pregnancy.pdf
- Online life skills course using a CBT approach to changing the way people think and feel: www.livinglifeinthefull.com

If the woman is not in contact with mental health services and there is evidence of severe mental health difficulties – for example increased risk of suicide or self-harm, significant impairment of day-to-day functioning or evidence of psychotic symptoms – liaise with her GP and:

- Refer to a local community mental health team.
- Liaise with multidisciplinary team members involved in care or treatment regarding management of the illness.
mental health services. These facilities enable women to receive care and treatment while being able to continue to provide total care for their infant in a supported environment.

Similar facilities have been developed in parts of England and Wales, but access to such services remains fragmented across the UK. The first specialist unit in Scotland was opened in Glasgow in 2004, while the Northern Ireland Assembly (2010) is currently exploring the possibility of developing their first specialist unit for women. Most services across the UK are provided on a regional basis. It should be emphasised that it is only a small percentage of women who will experience severe postnatal mental illness and require admission to such specialist facilities.

It is important to note that staff of all disciplines working with women affected by any mental disorder during pregnancy or in the postnatal period should have access to appropriate supervision, advice and training. This is vital to ensure the various and sometimes complex needs of women and families are considered, assessed and appropriately managed across the whole patient pathway from pre-conceptual care, through pregnancy, childbirth and the postnatal period. Communication and understanding of other healthcare professionals’ roles and limitations are essential to ensure good patient care and appropriate referral if necessary.

**Time out 4**
Consider the referral pathway in Figure 2. What services are available in your local area? Would you be able to access the services and resources identified? Adapt the pathway to reflect local referral pathways.

### References


Postnatal depression has potentially serious implications for the women affected, their children, partners and carers. The ability to identify the disorder, differentiate between mild, moderate and severe symptoms and demonstrate an understanding of its far reaching effects will enable better care delivery and improved patient outcomes. Health professionals also need to be able to recognise the difference between a woman with postnatal depression and a woman who is adjusting to altered life circumstances and the additional demands of caring for a newborn baby. This will enable appropriate referral for those women who require specialist help and those who simply need to be supported through this transition.

Policy documents, reports and guidelines have been developed to support the delivery of appropriate services. Referral pathways for those affected by any mental disorder during pregnancy and postnatally help to ensure faster access to services, as well as identifying the care and treatment they can expect to receive should they need to seek help.

Conclusion

Now that you have completed the article you might like to write a practice profile. Guidelines to help you are on page 60.

**Time out 5**

Identify ways in which you might alter your practice to address the needs of children, partners and carers of women affected by postnatal depression. Consider how partners and carers can also support women during their recovery.

**Time out 6**

Now that you have completed the article you might like to write a practice profile. Guidelines to help you are on page 60.