

CBT Practitioner Questionnaire from the Surviving Crying Feasibility Study

SUPPORT SESSION RECORD FORMS

These forms should be completed by the practitioner to monitor progress and provide research data. There are four types of form:

PARENT GENERAL DATA. This is completed once to store basic information about a parent and family.

CONTACT FORM. This form should be used to record all contacts with parents, it could be a short contact e.g. a phone call, text or e-mail either to arrange sessions or in-between sessions. Attendance at a one-to-one or group session is also counted as a contact and needs to be recorded here though full details of the session will be recorded on the session form. One line of this form should be completed after each contact, whether initiated by a parent or the practitioner.

SESSION FORM. A 'session' is a longer interaction or meeting that is arranged beforehand, usually to deliver the practitioner intervention. Sessions can be 1-to-1 or involve a small group, there is a separate form for one to one sessions and another for groups. One of these forms should be filled in after each session.

PRACTITIONER WEEKLY RECORD. This form is designed to collect data to allow the costs of delivering the practitioner support sessions to be measured. Please fill it in weekly to log the time spent in providing the sessions and the associated costs.

PARENT GENERAL DATA FORM

Parent's name:
Health visitor name and team:
Child(ren) name(s):
Parent contact details: Tel (mobile and landline): Email: Address: Parent's preferred method of contact:

CONTACT FORM

(This form should be used to record all contacts with parents, it could be a short contact e.g. a phone call, text or e-mail either to arrange sessions or in-between sessions. Attendance at a one-to-one or group session also counts as a contact and needs to be recorded here though full details of the session will be recorded on the session form. One line of this form should be completed after each contact, whether initiated by a parent or the practitioner)

[illegible]

SESSION FORM FOR ONE-TO-ONE SESSIONS

(A 'session' is a longer interaction or meeting that is arranged beforehand, usually to deliver the practitioner intervention. One of these forms should be filled in after each session).

1. Name of parent:		
2. Date and time of session: Date: _____ Time: _____ (am or pm?)		
3. Type of session	How long was it planned to last	How long did it actually last
1-to-1, face-to-face meeting of a practitioner with 1 parent	_____ hrs. _____ mins.	_____ hrs. _____ mins.
1-to-1 phone discussion between a practitioner and 1 parent	_____ hrs. _____ mins.	_____ hrs. _____ mins.
1-to-1 internet discussion between a practitioner and 1 parent	_____ hrs. _____ mins.	_____ hrs. _____ mins.

	In a parent's or parents' home	In a clinic/ treatment centre	In another place (please specify where this was)
4. Where did this session take place?			

5. Did a child attend the session?

Yes (If yes please record child's age and sex)	
No	

6. Had this parent done the home activities? (please tick a box)

No homework activities set	
Parent had done homework activities	
Parent had tried but been unable to complete the home activities:	
Parent had not done any home activities:	

7. Did the session otherwise go as planned: Yes _____ No _____

If No, please explain what occurred:

8. Which supplementary topic(s) were included in this session (please tick all that apply):

<input type="checkbox"/>	How to manage the stress of a baby's unsoothable crying
<input type="checkbox"/>	Arranging social supports and asking for help when needed
<input type="checkbox"/>	Relaxation and diaphragmatic breathing
<input type="checkbox"/>	Getting good-enough sleep and exercise
<input type="checkbox"/>	A topic was planned, but not included
<input type="checkbox"/>	No topic was planned
<input type="checkbox"/>	Others not detailed here – please specify

9. How would you rate this session (please tick one and provide comments in the box below):

Highly successful	Moderately successful	A bit successful	Unsuccessful
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please explain your rating:

SESSION FORM FOR GROUP AND PARTNER SESSIONS

(A 'session' is a longer interaction or meeting that is arranged beforehand, usually to deliver the practitioner intervention. One of these forms should be filled in after each session. Please also record parent attendance on the contact form).

1. Names of parents attended:

2. In total, how many parents attended this session:	Number of parents
How many of these were mums:	
How many of these were dads:	
How many of these were female partners:	

3. Date and time of session: Date:	Time:	(am or pm?)
------------------------------------	-------	-------------

4. Type of session	How long was it planned to last	How long did it actually last
Group face-to-face meeting between a practitioner and parents	_____hrs. _____mins.	_____hrs. _____mins.
Group phone discussion between a practitioner and parents	_____hrs. _____mins.	_____hrs. _____mins.
Group internet discussion between a practitioner and parents	_____hrs. _____mins.	_____hrs. _____mins.

	In a parent's or parents' home	In a clinic/ treatment centre	In another place (please specify where this was)
5. Where did this session take place?			

6. Did a child attend the session?

Yes (If yes please record child's age and sex)	
No	

7. Which parents had done the home activities? (please list names where applicable)

	Parent Name
No homework activities set	
Parent had done homework activities	

Parent had tried but been unable to complete the home activities:	
Parent had not done any home activities:	

8. Please write numbers in one or more of the boxes below to identify any attendance issues that occurred (write 0 if everyone attended).

	How many parents?
One or more parents contacted you beforehand to cancel taking part (please write how many)	
One or more parents failed to show up (please write how many and also include this information on the parents individual contact form)	
One or more parents left the session early (please write how many)	
One or more parents attended late (please write how many)	

9. Did the session otherwise go as planned: Yes _____ No _____

If No, please explain what occurred:

10. Which supplementary topic(s) were included in this session (please tick all that apply):

<input type="checkbox"/>	How to manage the stress of a baby's unsoothable crying
<input type="checkbox"/>	Arranging social supports and asking for help when needed
<input type="checkbox"/>	Relaxation and diaphragmatic breathing
<input type="checkbox"/>	Getting good-enough sleep and exercise
<input type="checkbox"/>	A topic was planned, but not included
<input type="checkbox"/>	No topic was planned
<input type="checkbox"/>	Others not detailed here – please specify

11. How would you rate this session (please tick one and provide comments in the box below):

Highly successful	Moderately successful	A bit successful	Unsuccessful
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please explain your rating:			

PRACTITIONER WEEKLY RECORD

This record is designed to collect data to allow the costs of delivering the practitioner support sessions to be measured. Please fill it in weekly to log the time spent in providing the sessions and the associated costs. Times should be entered to the nearest half-hour.

Week ending: _____ (please fill in date)

1. Time spent:

	Hours, to nearest 0.5hr
No. hours spent in 1-to-1 sessions with one parent during this week:	
No. hours spent in small group sessions with parents during this week:	
No. hours spent in telephone contacts with parents during this week:	
No. hours spent texting, e-mailing or other internet contacts with parents during this week:	
No. hours spent preparing for sessions:	
No. hours spent filling in record forms:	
No. hours spent on any other Surviving Crying activities (please write what these were):	

2. In total, how long did it take you to travel to the sessions: _____ Minutes

3. If you used public transport or travelled by taxi, what was the total cost of the fares?

£ _____

4. If you travelled by private car, how far in total did you travel to and from the sessions:

_____ Miles (to nearest mile)

5. If you travelled by private car, how much was paid in car park fees? £ _____

	Total costs to nearest £	What was this for?
6. Did you incur any other expenses on Surviving Crying activities? If yes, please say how much and what they were.		

Demographic Questionnaire for Stage 1 of the Surviving Crying Feasibility Study

Participant Demographic Information

Section 1: About You

Your current age: _____

Your ethnic group (*Tick one option that best describes your ethnic group or background*):

White			
English/Welsh/Scottish/Northern Irish/British		Irish	
Gypsy or Irish Traveller		Any other White background	
Mixed/Multiple ethnic groups			
White and Black Caribbean		White and Black African	
White and Asian		Any other Mixed/Multiple ethnic background	
Asian/Asian British			
Indian		Pakistani	
Bangladeshi		Chinese	
Any other Asian background			
Black/African/Caribbean/Black British			
African		Caribbean	
Any other Black/African/Caribbean background			
Other ethnic group			
Arab		Any other ethnic group	

Your educational history and qualifications (*please tick all that apply*):

Completed primary school education		Higher post-A level vocational qualification	
Completed secondary school education		Undergraduate degree	

GCSE/O level/NVQ Level 2		Postgraduate degree/qualification	
A level/NVQ Level 3			
Other (please describe any other educational experience or qualifications)			

Your employment status for all or most of the time your baby cried excessively (*please tick one*):

Employed full-time		Employed part-time	
Maternity leave from full-time employment		Maternity leave from part-time employment	
Not in paid employment		Self-employed	
Unemployed and looking for work		Student	
Other (please describe)			

Your marital and living arrangements at the time when your baby cried excessively (*please tick one*):

Married or living with partner		Living alone but supported by partner	
Living with parents or friends		Single parent living alone	
Other (please describe)			

Your Health Visitor's name: _____

Part 2: About Your Children

Please tell us about the current age(s) of your children and which one(s) cried excessively:

Child's name	Child's current age	Boy or girl	Did they cry excessively?

Please can you give us more information about each of your children who cried excessively:

First child's name:

How old was your baby when they **started** crying excessively?

How old was your baby when they **stopped** crying excessively?

When they were crying excessively, did they have any of the following problems? *(please tick all that apply)*:

	Yes	No	Please give more information
They had a fever			
They seemed unwell			
They had problems with feeding			
There were concerns about their weight gain			

How was your baby being fed at the time they started crying excessively *(please tick one)*:

Breast milk only		Breast plus formula milk	
Formula only		I can't remember	

Was their feeding checked by a professional? Yes / No If so who? (e.g. Health Visitor, GP)

.....
Was their weight checked by a professional? Yes / No If so who? (e.g. Health Visitor, GP)

.....
If you had any other children who cried excessively, please fill in the same information about them on the next page.

Thank you for taking the time to complete this information

Second child's name:

How old was your baby when they **started** crying excessively?

How old was your baby when they **stopped** crying excessively?

When they were crying excessively, did they have any of the following problems? *(please tick all that apply)*:

	Yes	No	Please give more information
They had a fever			
They seemed unwell			
They had problems with feeding			
There were concerns about their weight gain			

How was your baby being fed at the time they started crying excessively *(please tick one)*:

Breast milk only		Breast plus formula milk	
Formula only		I can't remember	

Was their feeding checked by a professional? Yes / No If so who? (e.g. Health Visitor, GP)

.....

Was their weight checked by a professional? Yes / No If so who? (e.g. Health Visitor, GP)

.....

Thank you for taking the time to complete this information

Demographic Questionnaire for Stage 2 of the Surviving Crying Feasibility Study

Stage 2 Demographic Information

Section 1: Dates

1.1 Date of completing questionnaires: _____

1.2 Date of consent: _____

Section 2: About You

2.1 Your current age: _____ years

2.2 Your sex: Female _____ Male _____

2.3 Your ethnic group (*Tick one option that best describes your ethnic group or background*):

White			
English/Welsh/Scottish/Northern Irish/British		Irish	
Gypsy or Irish Traveller		Any other White background	
Mixed/Multiple ethnic groups			
White and Black Caribbean		White and Black African	
White and Asian		Any other Mixed/Multiple ethnic background	
Asian/Asian British			
Indian		Pakistani	
Bangladeshi		Chinese	
Any other Asian background			
Black/African/Caribbean/Black British			
African		Caribbean	
Any other Black/African/Caribbean background			
Other ethnic group			
Arab		Any other ethnic group	

2.4 Are you able to speak English or are you being supported by an English speaker in completing this questionnaire (*please tick one option*):

English speaker	
Supported by an English speaking friend or family member	
Other (please specify)	

2.5 Your educational history and qualifications (*please tick all that apply*):

Completed primary school education	<input type="checkbox"/>	Higher post-A level vocational qualification	<input type="checkbox"/>
Completed secondary school education	<input type="checkbox"/>	Undergraduate degree	<input type="checkbox"/>
GCSE/O level/NVQ Level 2	<input type="checkbox"/>	Postgraduate degree/qualification	<input type="checkbox"/>
A level/NVQ Level 3	<input type="checkbox"/>		
Other (please describe any other educational experience or qualifications)			

2.6 Your employment status (*please tick one option*):

Employed full-time	<input type="checkbox"/>	Employed part-time	<input type="checkbox"/>
Maternity or paternity leave from full-time employment	<input type="checkbox"/>	Maternity or paternity leave from part-time employment	<input type="checkbox"/>
Not in paid employment	<input type="checkbox"/>	Self-employed	<input type="checkbox"/>
Unemployed and looking for work	<input type="checkbox"/>	Student	<input type="checkbox"/>
Other (please describe)			

2.7 Your marital and living arrangements (*please tick one*):

Married or living with partner	<input type="checkbox"/>	Living alone but supported by partner	<input type="checkbox"/>
Living with parents or friends	<input type="checkbox"/>	Single parent living alone	<input type="checkbox"/>
Other (please describe)			

2.8 Your (or your partner's) most recent pregnancy and childbirth (*For each question, please tick yes or no and add details if yes*)

	Yes	No	If yes, please explain
Did any complications arise during your (or your partner's) recent pregnancy?			
Did any complications arise during your (or your partner's) labour and childbirth?			

2.9 NHS contacts in the last year (**excluding** pregnancy and giving birth):

	No. times seen GP	No. times attended hospital	No. times seen another health service professional
In the last year, how many times have you seen your GP, attended a hospital, or seen another health service professional, because of concerns about physical problems or illnesses?			
In the last year, how many times have you seen your GP, attended a hospital, or seen another health service professional, because of concerns about stress, anxiety or your psychological wellbeing?			

Section 3: About Your Children

3.1 Please tell us about the current age(s) of your children and which one(s) cried excessively:

	Child's current age (in months if less than 1 year; weeks if less than a month)	Boy or girl	Please tick if he/she did (or does) cry excessively:
Child 1	Years: _____ Months: _____ Weeks: _____		
Child 2	Years: _____ Months: _____ Weeks: _____		
Child 3	Years: _____ Months: _____ Weeks: _____		
Child 4	Years: _____ Months: _____ Weeks: _____		

Thank you for taking the time to provide this information!

Focus Group Questionnaires and Rating Scales from Stage 1 of the Surviving Crying Feasibility Study

1. Which sources of information about crying and baby-care did you use with your baby?

Sources of information	Which sources did you use? (please tick all sources used)	How useful were they: 3 = Very useful 2= bit useful 0= not useful	Please name the source, if possible:
Leaflets from hospital, Doctor or Health Visitor			
Magazines			
Books			
Websites			
Telephone apps			
Phone conversation with Health Visitor, Doctor or other professional			
Visit to speak with Health Visitor, Doctor or other professional			
Online discussion boards			
Other (please explain)			

1a. We are interested to know what resources and support would have been most helpful to you when your baby was crying excessively. Please tick the boxes below to say which things you would have most liked.

Resources and Support	Would have liked a lot	No Preference	Would not have liked
Extra visits from Health Visitor			
Extra phone calls from Health Visitor			
Leaflets			
Website with information			
Online activities to complete			
Online discussion boards			
Facebook group			
A group to meet with other parents			

Materials Feedback Form

Name of materials: *[NB separate customised forms were produced for the 4 sets of materials]*

Please give us your opinion of these materials by answering the questions below:
(Please tick the appropriate answer)

1. How attractive did you think the materials were?

Very Attractive	Attractive	Adequate	Unattractive	Very Unattractive

2. How clear was the information in the materials?

(Could you understand it? Was it well-presented?)

Very Clear	Clear	Adequate	Unclear	Very Unclear

3. Did you find the information helpful and relevant?

(Would you have found this helpful when your baby was crying excessively?)

Very Helpful	Helpful	Adequate	Unhelpful	Very Unhelpful

4. What did you particularly like about these materials?

--

5. Which of the following aspects of the materials did you like?

	Really liked	Liked	Thought was OK	Neither liked or disliked	Did not like	n/a
Practical suggestions						
Reassurance that I wasn't doing anything wrong/ it wasn't my fault						
That I could trust what they said						
Other parents' experiences and ideas						
Expert opinion and advice						
That the information is aimed at both parents						
Videos						
Workbooks						
Interactive materials – responsive to your interests & concerns						
That the materials were easy to access when you need them						

6. Were there any other aspects of the material that you thought were important?

--

7. Was there anything you disliked about the materials?

--

8. How do you think the materials could be improved?

--

9. Overall how would you rate this material? *(please circle your answer)*

3
Excellent

2
Good

1
Adequate

0
Poor

10. How important do you think it is that materials like these are included as part of NHS care?

Very important	Important	Neither important nor unimportant	Not very important	Not at all important

Thank you.

2. Now you have seen all four packages, please put them in your order of preference? Put 1 for your first choice, 2 for second choice and so on.

Name	
PURPLE	
What Were We Thinking	
Cry Baby	
Coping with Crying (NSPCC)	

Please tell us why you prefer this package

3. Support Sessions

Please can you give us your thoughts on support sessions for parents of crying babies. Please circle the answer that is relevant to you.

- a) If you had been offered support sessions, would you have wanted them?

YES / NO

- b) Would you have liked these to be one-to-one or group sessions?

One-to-one / Group / Both

- c) How many sessions would you have liked?

1 2 3 4 5 6

- d) How long would you have liked the sessions to be?

Half an hour 1 hour 1 ½ hours 2 hours

Have you any further comments you would like to make about any of these issues?

4. What is the best format for presenting information to parents?

Source/format of information	Rate this format: 3 = highly effective 2 = effective 1 = adequate 0 = poor	Please explain your rating
Leaflets from hospital, Doctor or Health Visitor		
Websites		
Telephone apps		
Phone conversation with Health Visitor, Doctor or other professional		
Visit to speak with Health Visitor, Doctor or other professional		
Other (please explain)		

5. Which devices do you use to access the internet – websites and social media? (Please tick all that apply)

Type of device	Which devices do you use? (Please tick all devices used)
Desktop computer	
Laptop/ workbook	
Tablet	
Phone	
n/a	

6. Which device do you prefer to use to access the internet – websites and social media?

Type of device	Which device do you prefer to use? (Please tick only one)
Desktop computer	
Laptop/ workbook	
Tablet	
Phone	
n/a	

Stage 2 Baseline Questionnaires from the Surviving Crying Feasibility Study

Date of completion: _____

Completed at: Baseline / Outcome

About Your Baby's Crying, Feeding and Health Interview Schedule

I'm going to ask some questions about your recent baby, who is (or has been) crying excessively. The questions are answered by ticking boxes or writing in a number. There are no right or wrong answers - the aim is to find out about your experiences so far. Later on, we will ask some of these questions again to find out how things have changed.

1. How old was your baby when he/she **started** crying excessively? _____ weeks
2. How old when he/she **stopped** crying excessively (write NA if still crying)? _____ weeks
3. How old is your baby **now**? _____ weeks

Crying Patterns Questionnaire - SECTION A (Please see the CPQ instructions on how to deliver these questions)

4. AMOUNT OF FUSS/CRYING IN EACH PERIOD OF A TYPICAL DAY:

(IF YESTERDAY'S CRYING TIMES, TICK HERE: ☐)

Morning 6am-midday	Afternoon Midday – 6pm	Evening 6pm – midnight	Night Midnight – 6am	Total (24 hours)
.....hoursminshoursminshoursminshoursminshoursmins

5. WHAT ABOUT BOUTS OF UNSOOTHABLE FRETTING AND CRYING? (periods when your baby fusses and cries and requires constant soothing or is hard or impossible to settle down)

(a) How many mornings per week included a bout or bouts of this kind?

What about: afternoons?
evenings?
night-times?
(record no. in each case. If none, record 0)

No. of mornings	No. of Afternoons	No. of evenings	No. of nights

	A severe problem	A large but not severe problem	A moderate problem	A minor problem	No problem at all
6. How much of a problem has your baby's crying been for you?					

	7 days	5- 6 days	3 - 4 days	1 - 2 days	none
7. How many days in the week has your baby's crying been a problem?					

	Extremely frustrated	Very frustrated	Moderately frustrated	A little frustrated	Not frustrated at all
8. How frustrated have you felt about your baby's crying?					

9. Remedies for the crying: for each possible remedy below, <i>please write how many times you have used it:</i>	How many times?
Remedy prescribed by a doctor (<i>please write what this was if known</i>)	
Change of formula feed	
Colic drops	
Herbal remedy	
Chiropractor	
Other remedies (please write what these were)	

10. How many times have you been in contact with your Health Visitor, GP, or anyone else because of concern about your baby's crying? (<i>For each type of contact below, please write in how many times this has happened since your baby was born.</i> <i>Please include all contacts where your baby's crying was discussed, even if they also had another purpose (e.g. weighing). Please <u>include</u> the contact which led to your involvement in this study.</i>	How many times?
Health Visitor visited you at home	
You went to a Health Visitor clinic	
Health Visitor contact over the telephone	
Health visitor contact by e-mail or internet	
GP visited you at home	
You went to a GP surgery	
GP contact over the telephone	
GP contact by e-mail or internet	
Someone else visited you at home (<i>please write who this was:</i>)	
You visited someone else (<i>please write who this was:</i>)	
Contact with someone else by telephone (<i>please write who this was:</i>)	
Contact with someone else by e-mail or internet (<i>please write who this was:</i>)	
Access to internet websites, chat rooms or social media (e.g. Facebook; Twitter: please exclude the Surviving Crying website)	

11. When crying excessively, did/does your baby have any of the following problems?
(please tick all that apply and provide any additional information available where the answer is yes):

	Yes	No	Please give more information
He/she had a fever			
He/she seemed unwell			
There were concerns about his/her weight gain			
He/she had problems with feeding			
He/she repeatedly brought up feeds			

12. How was your baby being **fed** at the time he/she **started** crying excessively *(please tick all that apply):*

Breast milk		Formula milk	
Baby solid foods		Family foods	

13. How is your baby being **fed at the moment** *(please tick all that apply):*

Breast milk		Formula milk	
Baby solid foods		Family foods	

14. If you have stopped breast-feeding, how old was your baby when you stopped: _____ weeks (*write NA if still breast-feeding*)

15. Has this baby's feeding been checked by a professional? Yes / No If so who? (e.g. Health Visitor, GP)

16. Has this baby's weight been checked by a professional? Yes / No If so who? (e.g. Health Visitor, GP)

17. Please provide more information about this baby's overall health and wellbeing. *For each question, please tick yes or no and provide details if yes.*

	Yes	No	If yes, please provide details
Was he/she admitted to the hospital Special Care Baby Unit in the first week after being born?			
Apart from the crying, has he/she shown any signs of being unwell in the last fortnight?			
Apart from the crying, has he/she been taken to a GP, paediatrician, or other doctor in the last fortnight?			

Thank you for completing this interview.