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Giving birth to hope:

group work for women with postnatal depression

Group therapy can be of great benefit to women with postnatal depression, even though it is not recommended in NICE guidelines, writes **Karin Parkinson**

The long-term risks of postnatal depression to the mental health of mothers, the emotional, cognitive and social development of infants, the health and development of the mother-infant relationship and the marital relationship are well known and supported by research[1,2]. In 2007, the National Institute for Health and Clinical Excellence (NICE) produced guidelines for the treatment of antenatal and postnatal mental health issues, which recommend three stepped-care interventions: 1) guided self-help strategies, 2) non-directive counselling (listening visits, usually carried out by health visitors) and 3) brief cognitive behaviour therapy (CBT) or interpersonal psychotherapy (IPT)[2]. The guidelines note the paucity of research comparing the effectiveness of different psychological and psychosocial interventions for postnatal depression, and only one study is cited that considered group work for postnatal depression[2]. However, colleagues and I developed and have run a therapy group for women with postnatal depression in Islington over a number of years, and have found it to be highly effective. While I am aware that time-limited therapy groups for such clients have been facilitated by psychologists and counsellors from time to time, I am not aware of other ongoing groups of the type I describe below, and I would welcome hearing from therapists involved in such projects. Irving Yalom said that the instillation of hope was a key therapeutic factor in any group[3]. This article describes the development and evaluation of a group which has been bringing hope to women with postnatal depression for over eight years.

Group development

In 2000, working as an integrative counsellor for a GP practice based in a health centre in Islington, North London, I received a flurry of referrals for women presenting with symptoms of postnatal depression, which coincided with an initiative by Islington PCT to develop perinatal services. Health visitors were being trained and supervised by a clinical psychologist specialist in maternal mental health to provide six 'listening visits' for women identified as having postnatal depression using the Edinburgh Postnatal Depression Scale (EPDS), at a time before guidelines had been developed by NICE[2]. The child psychology department was developing clinics in health centres and children's centres, offering individual sessions of CBT for postnatal depression. This was a valued service, but the health visitors felt that a peer group would be helpful for women. Two health visitors and I made a proposal for a postnatal counselling group, which we planned to co-facilitate. We were delighted when it was accepted as a pilot. Then, in spite of the recognised importance of multidisciplinary collaboration[2], a desperate shortage of health visitors resulted in my facilitating the group alone. I attended a training course on running groups with psychologist colleagues, facilitated by a group analyst who later became my supervisor. My work continues to be funded by the PCT from the health visiting budget.

I describe the postnatal counselling group as being: 'For women finding the transition into motherhood challenging'.

> A service which has developed in response to a need, is deemed effective by those who refer to it and those who use it, and responds favourably to evaluation has a valid place in continuing to serve the local community

Most mothers will acknowledge that the challenges associated with every new baby are significant, however good the experience may be. A baby represents a new puzzle piece which must fit into the pre-existing family picture, and every other piece/person will need to change shape for this to happen adaptively.

Research has shown that some women are more likely than others to struggle with this transition and develop symptoms of postnatal depression. Risk factors include insecure primary attachments, a history of depression or mental illness, depressed mood or anxiety in pregnancy, recent difficult life events and poor social support[2,4]. The counselling group is a safe, confidential, non-judgmental place for women to share any thoughts and feelings concerning the arrival of their new babies; where even frightening and shameful things can be expressed. Unhelpful thinking and behavioural patterns that fuel depression can be addressed, and difficult life events, changing relationships and the losses and gains of parenthood can be shared.

The group gives social support, reducing the sense of isolation often reported by mothers with babies[1]. The value and importance of sharing with peers is clearly expressed in the following comments:

'I felt it was a place to escape to, where you are allowed to say anything.'
'It helped to admit to everything not being perfect...unlike in other mothers' groups.'
'It gave me the strength to face my feelings and helped me communicate with my husband about these feelings.'
'I appreciated the feeling of community that I feel is so much missing in my life.'

Group format

The postnatal counselling group meets for 90 minutes weekly with a maximum of eight members who commit to attend six consecutive sessions. Every six weeks, participants choose to continue or leave, and new members may join. The six week contract may be renewed three times, so group membership can be for up to six months and indeed longer, given breaks for holidays.

Initially I was concerned that six weeks would be insufficient to allow trust to develop in the group, but the members proved me wrong. Indeed, the positive comments of existing participants proved instrumental in bringing hope to newcomers. Frequent entry points allow women to join relatively soon after referral. This is especially important for this client group, for whom healthy early attachments are vital for the future of their children.

A crèche is available for the use of group members, and takes a maximum of six babies over three months old. Women are seen for a first appointment as soon as possible even if their baby is too young for the crèche, as this reassures the future group member. Women who can easily arrange child care are encouraged to do so since there is a discrepancy between group membership and crèche places, due to financial constraints. The group is ongoing, following the pattern of school terms.

Clinical supervision was at first provided by the psychologist, mentioned previously, who trained and supervised health visitors in listening visits, thus providing a helpful link between the professions and allowing a sharing of perspectives. However, due to managerial changes, I now attend group supervision facilitated by the analyst who ran the training in group work.

Location

I have been fortunate in having the full collaboration of New River Green Children's Centre, which provides the premises and crèche facilities. The importance of such support cannot be over emphasised. The welcoming atmosphere and friendly disposition of the staff encourages reluctant women to engage with the group. Baby massage, baby play sessions and a toy library are just some of the services available at the centre, so interest in the group provides a bridge for isolated women to access other community services. The non-medical setting also reassures women and helps to normalise their experience, reducing the stigma they can often feel on receiving a diagnosis of postnatal depression.

Referral

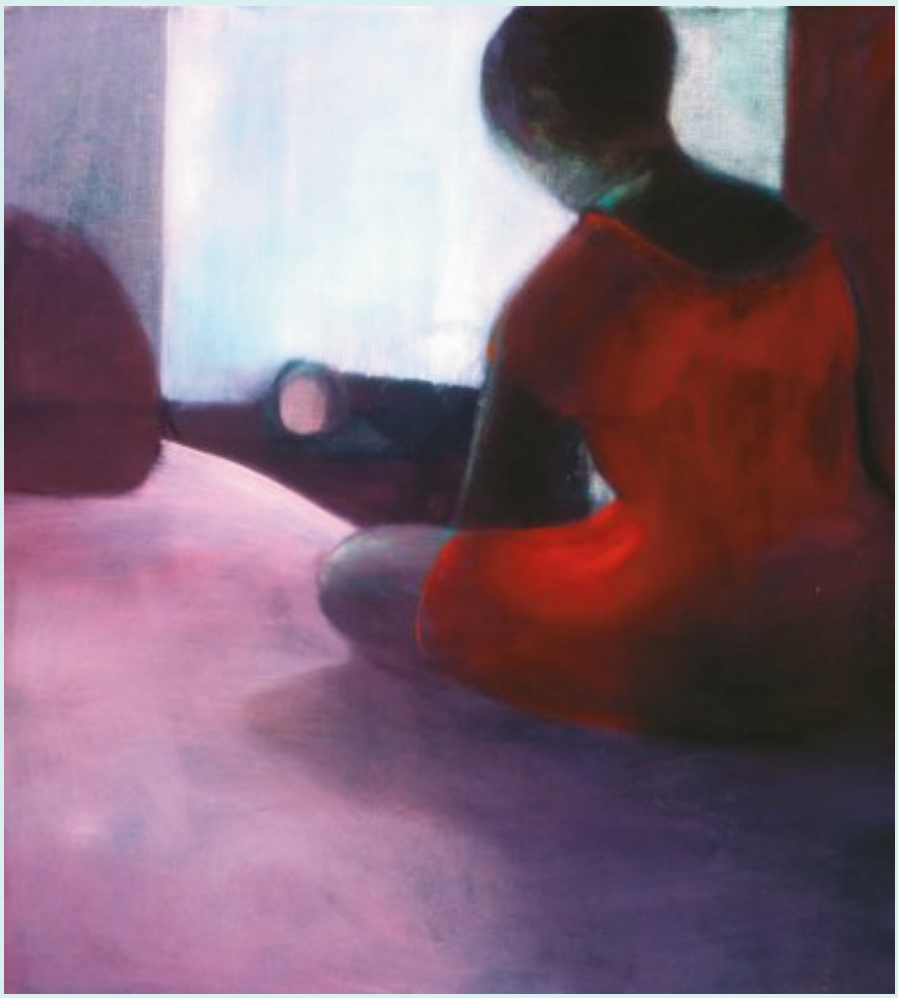
Since the implementation of NICE guidelines for perinatal care in Islington, the postnatal counselling group has retained its position at levels 2 and 3 in the stepped-care hierarchy, as a service for women with mild to moderate postnatal depression and those recovering from severe postnatal depression. Since poor communication has often been identified as a reason for poor quality care[2], I make every effort to communicate with potential referrers in all the relevant professions. This entails periodic attendance at team meetings of GPs, psychologists, counsellors, health visitors, midwives, social workers, family support and nursery workers, as staff turnover is inevitable, together with the distribution of paper and email information; attending and/or participating in PCT events concerning perinatal issues, and contributing to case conferences.

Once it has been established that a woman may benefit from attending, the referrer tells her about the group and if she is interested, permission is obtained for me to contact her. This will usually happen the following week, and she will be invited to meet me at the children's centre to find out more and decide whether she would like to attend. Women who are known to be at risk are sometimes referred during pregnancy. Knowledge of the group supports these women, and our meeting gives them an opportunity to share anxieties and prepare for the transition to motherhood, reducing the risk of postnatal depression. To date, most referrals have come from health visitors and GPs, though the breadth of referral sources is growing. Some clients self-refer, having seen posters about the group.

When a client has made her decision, I ask her permission to send a letter to her GP, and copy this to her referrer and health visitor for their information. No other contact with health professionals is routinely made unless there is concern regarding a client's or baby's wellbeing.

Clients

Group membership can be extremely diverse, including women from different cultures, social, economic and educational backgrounds. One woman commented: 'I like this group as I get to know people I never would otherwise'. It seems that the communality of motherhood, in conjunction with non-judgmental respect for others, is able to breech many of the gaps created by difference. When the group was evaluated after five years, it was found that 36 per cent of participants described themselves as black or from an ethnic minority (BME). The percentage of BME people in the population of Islington in the 2001 census was 24.7 per cent, so this represents good use of the service by ethnic minorities.



First appointments

The advantage of networking with other professionals is that they then know to whom they are referring clients. This makes it easier for them to encourage an anxious client to take the first step towards joining the group, and to assure her that there is no obligation to join as a consequence of meeting me.

First appointments take place at the children's centre. This allows clients to practise the journey, familiarise themselves with the premises and visit the crèche. They discover other activities at the centre, which then becomes a place not just for their own emotional needs, but for their baby, other children and indeed whole family. The unknown becomes more familiar and anxiety is reduced.

My meeting with clients gives them reassurance that they will know at least one person in the group. We meet in the group room and they learn that:

- There is a six-week contract and renewal system, and most people choose to stay between 12 and the maximum of 24 weeks.
- The group is a place for up to eight women to bring their thoughts and feelings about what is happening to them since the arrival of their baby.
- There are no designated weekly topics, and people usually start by speaking about what has happened to them over the week.
- They can say as much or little as they wish about anything that concerns them, but agreeing to the contract of confidentiality is an

absolute requirement for being in the group. The boundaries of confidentiality in terms of my supervision, the safety of participants and communication with professionals are made explicit.
■ They may be surprised at the kind of things they talk about; possibly issues they would not easily share in another setting such as a baby drop-in.
■ Group members are unique, coming from any number of social, cultural and ethnic backgrounds, each with their own story. While clients may feel that their concerns are minor compared with those of others, each individual's experience is considered important.
■ The facilitator's job is to ensure that everyone feels safe and comfortable enough to share their concerns, reflect on themes that emerge in the discussion, and make connections between these themes and the different experiences of members. The group may negotiate a contract with the facilitator, eg when there are many vocal members, the facilitator may be 'contracted' to interrupt 30 minutes before the end to check whether anyone has been holding an issue that they want to share.
■ Babies are not present in the group because they are distracting and may pick up group members' distresses. However, the group may negotiate an exception, for example a quiet, breast-feeding baby may join the group so that his or her mother does not miss most of the session.
■ Leaving a baby in the crèche can be hard, but the crèche workers will *always* come and fetch a mother if her baby cannot be settled. It is okay for members to check on their baby during sessions to help them to be more present in the group.
■ Running late need not stop a woman attending. Mothers know that babies often need attention just when they are leaving home! The group will be in full flow when she arrives, so not receiving an immediate hello must not be taken as rejection. She can take her time to settle and 'filter' in.
■ Members are requested to tell the group about contact with other members outside the group. This helps to maintain a common basis of experience, and protects against the development of sub-groups. Contact outside the group is likely as members will be accessing the same services.
■ It is important for group members to let me know if they are unable to attend. Each woman is a part of the group even in her absence, and others will ask about her. I will return calls, out of courtesy and concern.
■ When a woman leaves the group, she will be asked to complete the EPDS, which she first completed at referral, for a second time, and to fill in a feedback questionnaire. (The use of the EPDS is not recommended by NICE as a screening tool for postnatal depression[2], but it is endorsed for routine monitoring of outcomes[2]). This gives quantitative and qualitative data that can be analysed statistically to provide information about the effectiveness of the service and users' experience of it. This data may be used to promote the development of the service.

Some clients, recognising that their partners are also struggling with the transition to parenthood, ask whether there is a service for fathers. It is hard to bring fathers together as they often cannot attend daytime appointments. This and the limited resources available mean that I have not developed this important idea to date.

Facilitator roles and interventions

At the start of the first group session, we re-visit and agree the ground rules for the group. I also pre-empt common embarrassments by naming and normalising the fact that members may speak with their tears, and that there may be silences for reflection. I invite members to introduce themselves and share any hopes or fears that they have about the group. From then on, the use of the therapeutic space is almost always client-led.

As a therapist, I aim to create the conditions needed for clients to share as much as they wish, in their own time. From the material presented I may:
■ Reflect back a theme that emerges from the content, as this may bring other group members into the discussion.
■ Wonder out loud about the impact a comment appears to have had on the group or some people in the group, thus giving members an opportunity to risk eg naming difficult feelings or exploring relationship issues within the group.
■ Facilitate different ways of thinking by making interventions that challenge the group's thinking about an issue.
■ When one person dominates the group for a significant period, remind that person of comments made previously by other group members that may be helpful to their issue. In this way others are included and their support for the individual is acknowledged.

The interventions mentioned above illustrate the integrative approach used. The awareness and active use of interventions relating to process, group and interpersonal dynamics in the room (as well as those at home caused by the arrival of a new baby) incorporate the principles of IPT. Challenges to core beliefs, thinking and behaviour are informed by CBT. Client-centred principles are modelled to encourage group members to be genuine, congruent and non-judgmental. In my experience these models ebb and flow effortlessly together if they are used when the time is right, responding to the organic dynamic of the group.

The non-directive nature of the group demonstrates a basic trust in the members' willingness to bring material that will help them heal themselves. Empathic reflection of content, affect and themes facilitates deeper exploration. Individuals have often made significant changes in their thinking about themselves and others. One woman said: 'I am more understanding of people's reactions and the reasons for their reactions'. When individuals share their thoughts with the group, they are both challenged and supported in their efforts to change associated behaviour. Other group members are then often encouraged to address their own issues.

Group evaluation

In 2005, after five years of ongoing service, the group was evaluated. The hypothesis that it is an effective intervention for postnatal depression was tested on a small sample of pre and post-group EPDS returned evaluations (27) using the Wilcoxon test, which showed that the

difference between them was highly significant (t=4.29; p=0.01).

The answers to 39 completed satisfaction questionnaires showed that 38 participants found the group useful while one was unsure. Of the 39, 26 found it easy to speak in the group, 34 felt understood, and 20 noted 'some' and 17 'considerable' change for the better. Participants also made comments about feeling supported, less isolated, calmer and more able to understand others, relieved to be able to share their true feelings, and having improved self-esteem and increased confidence. Some shared their sadness at leaving and their appreciation of the crèche staff.

Concluding points

NICE guidelines for antenatal and postnatal mental health do not recommend group counselling as a treatment for postnatal depression, since the research evidence is lacking. Instead they suggest stepped-care interventions, including individual non-directive counselling (listening visits, usually carried out by health visitors) at step 2 and individual brief CBT or interpersonal psychotherapy (IPT) at step 3. The postnatal counselling group described here incorporates interventions from steps 2 and 3, as appropriate. However, this happens in the context of peer support, which is invaluable in helping to normalise the women's experience and reduce their sense of isolation, and this support often continues after they have left the group.

The jury is still out on whether or not following a specific psychological model described in a manual is more effective than responding to the group process[5]. It has been suggested there may be some disadvantage in adhering too rigidly to a manual which should be seen rather as a map or metaphor[1]. I think we need to remember that being a therapist is not just about *what* we do but also *who* we are in the client-therapist relationship.

The evaluation of this postnatal counselling group showed that group therapy can be effective. This was carried out with minimal time and tools and does not claim to be a rigorous piece of research conclusively proving the effectiveness of group therapy for postnatal depression. Indeed I would welcome the funding for more research to confirm the benefits conclusively, particularly given the important additional benefits of peer support that I have observed, not to mention the potential cost-effectiveness of group therapy. However, until there is clear research evidence disproving its effectiveness, I believe that a service which has developed in response to a need, is deemed effective by those who refer to it and those who use it, and responds favourably to evaluation has a valid place in continuing to serve the local community. ■

Karin Parkinson is a BACP accredited counsellor and supervisor in private practice. She is also currently counselling in primary care, supervising for the Mapesbury Clinic, a voluntary service for refugees and asylum seekers, and is a skills trainer at the Minster Centre. She can be contacted by email at karinsplace33@gmail.com

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Can antenatal counselling prevent postnatal depression?

Counselling undertaken antenatally has a positive effect on postnatal emotional health, according to the findings of a small-scale study conducted by **Pam Brooks**

The prevalence, causes and treatment of postnatal depression have attracted much research interest and increased public awareness[1-5]. Researchers originally showed less interest in antenatal depression as pregnancy was traditionally thought to protect women from depression[6]. However, recent studies have found antenatal depression to be as prevalent as postnatal depression, in that it is believed to affect up to 13 per cent of women[6].

The focus of my research project, undertaken as part of an MA in counselling studies, was perinatal depression, ie mild to moderate depression occurring around the time of childbirth. My interest in this area developed through my professional role at North Manchester General Hospital as specialist counsellor in maternity and gynaecology.

The development of the project stemmed primarily from informal feedback from many clients suggesting that attending counselling antenatally was helping to alleviate distress postnatally. This seemed to contradict