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Institute of Health and Social Care

A RETROSPECTIVE EVALUATION ON THE PERCEIVED BENEFITS TO POSTNATALLY DEPRESSED WOMEN ATTENDING A SUPPORT GROUP BASED ON COMPASSIONATE-FOCUSSED COGNITIVE BEHAVIOURAL THERAPY

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ABSTRACT

Institute of Health and Social Care

MASTER OF SCIENCE IN COGNITIVE BEHAVIOURAL THERAPY

A Retrospective Evaluation on the perceived benefits to postnatally depressed women attending a support group based on compassionate-focussed cognitive behavioural therapy

by

Patricia Alexander

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Abstract

This retrospective evaluation explored the benefits to postnatally depressed women following attendance on a six week course based in the community running one day per week for two hours duration. Data for the evaluation was collected from the anonymous open-styled questionnaires completed at the end of the course. The course was facilitated by two NHS employees, one of whom was a student in cognitive behavioural therapy, and two charity workers. The group's programme was structured adopting a compassionate-focussed approach to cognitive behavioural therapy but also offered fluidity to allow for group participation and interactive learning.

A thematic analysis of the 30 questionnaires collected reveals a gentle opening up of the participants as they move from a critical-self to a compassionate-self, where they are once more able to use the word 'happy'. The themes identified reflect that the group work had a positive influence on the women's self-esteem, their outlook on life and also encouraged on-going learning, whereby techniques learnt during the course are transferred into everyday life.

The implications for practice offer hope for the treatment of postnatally depressed women, not only to the women themselves, but to those involved in their care. The delivery of similar courses may help to continue the personal benefits gained by women who are suffering from postnatal depression in addition to offering on-going support that is provided through inter-agency working for the mother and her wider family network.

DISSERTATION ACRONYMS

CBT	COGNITIVE BEHAVIOURAL THERAPY
CFCBT	COMPASSIONATE-FOCUSSED COGNITIVE BEHAVIOURAL THERAPY
DH	DEPARTMENT OF HEALTH
EPDS	EDINBURGH POSTNATAL DEPRESSION SCORE
GP	GENERAL PRACTITIONER
HV	HEALTH VISITOR
NICE	NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE
NHS	NATIONAL HEALTH SERVICE
NPS	NON-PROBABILITY SAMPLING
NPSA	NATIONAL PATIENT SAFETY AGENCY
PND	POSTNATAL DEPRESSION
PPD	POSTPARTUM DEPRESSION
SSSG	STEPPING STONES SUPPORT GROUP
WHO	WORLD HEALTH ORGANISATION

Introduction

This study has evolved from life experience stretching back many years that has created an interest in mental health first developed during volunteer years in India. These years involved work with minority groups and an immersion in the Indian culture through a six-month stay at a Classical Yoga Institute. It was here that an understanding of the importance of a holistic approach to health was first recognized viewing the body, mind and spirit as integral to each other. On return to the United Kingdom this was further enhanced through studies into complementary medicine.

This integrated approach to life has subsequently influenced the approach to work as a health visitor guiding further studies in cognitive behavioural therapy, in order to address the high prevalence of postnatal depression amongst the women visited who come under the jurisdiction of this profession. The cognitive behavioural therapy has been further enhanced with the adoption of a compassionate focus to this therapy. This approach has been adopted for the running of the Stepping Stones Support group for women with children under five years of age, who are suffering from postnatal depression. It is this group, which will be evaluated within this study.

In the light of current research which suggests that depression has serious implications on the mother/child bonding (Bowlby, 1951) plus the mother/partner relationships (Bancroft & Ardley, 2008), this study fulfils the needs of many current government reports (Department of Health 2000, 2002b, 2006) plus the Cabinet Office paper (2006) on Social Exclusion. The retrospective evaluation therefore appears to be timely, especially at a time where the technological world is rapidly developing bringing with it a new outlook on communication and relaxation but also where the world is heralding an age when depression is claimed by the World Health Organization and World Organization of Family Doctors (2008) to be the leading cause of disability. At a time when an age of material gain is confronted with psychological pain, it would not appear to be out of order to question if the words of Jon Kabat-Zinn (2006), the pioneer of mindfulness within therapy, contain more than just a few elements of truth. These words are in relation to a meeting with the Dalai Lama who explained that the Tibetan culture was unfamiliar with the concept of low self-esteem when questioned by a Western psychologist in relation to feelings of self-loathing and inadequacy experienced by his clients.

> *'Maybe we are overdeveloped outwardly and*
> *underdeveloped inwardly. Perhaps it is we who,*
> *for all our wealth, are living in poverty.'*
>
> Jon Kabat-Zinn (2006 p. 163)

This study comprises a literature review which aims to justify the need for a retrospective evaluation to be undertaken and examines the abyss in today's approach to the management of depression. The methodology goes on to explain the techniques used to fulfil the aim of the study, at the same time maintaining a critical awareness of the limitations of the methods adopted. The results and discussion move on to embrace the information gleaned from the literature review in order to assess the relevancy and appropriateness of the Stepping Stones Support group in the management of postnatal depression. Finally the conclusion acts as an overseer to the whole study and attempts to draw together the essence of the retrospective evaluation and its pertinence in the care of the postnatally depressed woman.

Literature Review

Depression

Depression, as a mental illness, is complicated and unique to each individual. It is claimed by the World Health Organization (WHO) and World Organization of Family Doctors (WOFD) 2008, to be the leading cause of disability which, at its worst, may lead to suicide. The WHO and WOFD (2008) state that about 121 million people are affected with depression worldwide, while one in six British adults are experiencing anxiety or depression at any given time.

What is depression?

There are multiple definitions of depression that originate from the medical profession, voluntary bodies and the individuals themselves who are the victims of depression. The following definition is an extract taken from a well-known charity:

> *'Depression is a mood disorder characterized by low mood and a wide range of other possible symptoms, which will vary from person to person. An illness that can develop quickly or gradually, and be brought on by life events and/or changes in body chemistry. It can strike anyone, and is curable.*
> *Some experts look upon depression as a defence mechanism that one's body adopts in order to escape from unbearable stress. In some cases, it could even be a form of anger directed towards the self for not having lived up to one's expectations, which may well have been set too high in the first place.'*
>
> Depression U.K. (2008)

Additional components of depression identified by Beck et Alford (2009) include a negative self-concept; regressive and self-punitive wishes; vegetative changes such as anorexia or insomnia plus a change in activity. The WHO (2008) article on depression elaborates further by claiming that these components may become chronic, ultimately affecting the person's ability to take care of his or her everyday responsibilities. Depression however is not a new disease of the 21st century, records exist which date back to the time of Hippocrates (460-370 B.C.). It was in fact the Hippocratic School (Stefanis et Stefanis, 2002) which introduced the term "melancholia" to describe the symptoms of depression; and this term survived until the end of the 19th century.

Even today Beck et al (2009) observe that there remain unresolved issues in relation to the nature, classification and aetiology of depression. For example, Beck et al (2009) question whether depression is caused primarily by psychological stress and conflict or, alternatively, by a biological imbalance.

For the present day diagnosis of depression one of the two main systems is being used globally in order to ensure that the appropriate treatment is offered. The first diagnostic system is known as the International Classification of Diseases (ICD) currently identified under ICD-10 due to its tenth revision by the WHO (2004). The second diagnostic system is the Diagnostic and Statistical Manual of Mental Disorders (DSM-1V) of the American Psychiatric Association (2004), fourth edition. In the United Kingdom, depression is diagnosed using the latter system following the recommendations of the National Institute for Health and Clinical Excellence (NICE) 2009a.

NICE (2009a) defines depression as a range of mental conditions, which are characterized by persistent low mood, loss of interest and enjoyment in ordinary things and experiences in addition to a range of associated emotional, cognitive, physical and behavioural symptoms. Beck et al (2009) highlight the fact that the chief complaint of the depressed person centers on a physical symptom that is chararacteristic of depression. Cassidy et al (1957) cited by Beck et al (2009) analyzed the chief complaints of manic depressive patients and placed them into several categories in an effort to clarify the multiple presentations of depression. The categories and complaints are listed below and offer a broadened perspective on depression and its manifestation.

Psychological: "I have nothing to look forward to"; "afraid to be alone"; "get discouraged and hurt"; "black moods and blind rages"; "brooded around the house".

Localized medical: "head is heavy"; "urinating frequently"; "pain in head like a balloon that burst"; "upset stomach".

Generalized medical: "I'm exhausted"; "I can't do my work"; "I don't feel strong"; "I tremble like a leaf".

Medical and psychological: "I'm scared to death and can't breathe"; "stiff neck and crying spells".

Medical, general and local: "breathing difficulty … pain all over"; "I have no power. My arms are weak".

However Westbrook (2005), in a small self-help booklet written for the use of patients, classifies the symptoms in a more simplistic manner emphasizing that, for each person, the symptoms may vary. The symptoms which have not already been mentioned above include: self-criticism and guilt; finding it hard to be with people; difficulty in concentrating; changes in sleep pattern, appetite and weight; loss of interest in sex and thoughts of death.

From Symptoms to Diagnosis

The act of diagnosing depression following an assessment of the patient is itself fraught with controversy. Some professionals, including psychiatrists and psychologists, are critical of the method of diagnosis in the medical world as they consider that the diagnosis of depression is not helpful to the client and increases the risk of stigmatization and social exclusion. The European Pact for Mental Health (2011) includes stigma, social exclusion and mental health as one of its five thematic areas and is working towards promoting the social inclusion of people with mental health problems in Europe. These contentious issues of depersonalization and social exclusion have been captured by Barker (2009) who offers alternative perspectives to the DSM-IV diagnostic criteria. Barker (2009) has highlighted concerns that diagnosis interferes with the holistic approach to care and cites Fisher (2000), a psychiatrist and once a mental health patient himself, who shared how the neurobiological theory of mental illness deprived him of any sense of self-determination and responsibility. This opinion is supported by May (2007), also previously a patient due to his schizophrenia and who subsequently trained as a clinical psychologist in adult mental health. May (2007) is disturbed by the overpowering negative impact of diagnosis and clinical language on the patient and reckons that the patient's condition is exacerbated by the fact that the diagnosis makes the person become invisible due to the fact that the person is classed as a 'depressed person' rather than as a 'person who is suffering from depression'.

Keenan (1993) appears to reflect the concerns of Barker (2009) and May (2007) related to the loss of self through his passionate plea against the depersonalization of the patient:

> *'We cannot abandon the injured or the maimed, thinking to ensure our own safety and sanity. We must reclaim them as they are part of ourselves'.*
>
> Keenan (1993, p.288)

In this quote, Keenan (1993) is attempting to stress the importance of coming alongside those who are suffering and reflects the compassionate approach of Gilbert (2006) adopted in cognitive behavioural therapy.

It becomes apparent from the discussion on the diagnosis of depression that there exists conflicting approaches to the care of a person who is mentally ill. Barker (2009) considers that, when you are assessing somebody, you should listen to what they are saying and write the assessment down in their own words, otherwise the nurse or whoever is carrying out the assessment, will fashion what they hear and not the truth. Thomas et Pollio (2002) further believe that, when a person is interviewed by someone who is equally interested in their experience, the interviewee may not only gain access to more of his or her life history, but may also feel understood

The Patient's Perspective on Depression

In the light of the on-going difficulties as regards diagnosis plus the 'theoretical vacuum' which McLaren (2006) cited by Barker (2009) believes to exist in modern day psychiatry; it appears appropriate to open up new avenues of thought and approaches to care. In this regard it is crucial to consider the raw inner feelings of the patients themselves that will be conveyed with the use of direct quotes in order that the emotional content is not lost in translation. Barker (2009) conveys this intent when he writes 'let the words speak' in order to preserve genuine vital meanings. Barker (2009) considers that the understanding gained from learning of such disclosures will open up appropriate ways of caring.

The quote below describes the slow onset of depression until the patient feels totally overwhelmed:

> *'That fall, as the disorder gradually took full possession of my system, I began to conceive that my mind itself was like one of those outmoded small-town telephone exchanges, being gradually inundated by floodwaters: one by one, the normal circuits began to drown, causing some of the functions of the body and nearly all of those of instinct and intellect to slowly disconnect.*
>
> *There is a well-known checklist of some of these functions and their failures. Mine conked out fairly close to schedule, many of them following the pattern of depressive seizures. I particularly remember the lamentable near disappearance of my voice. It underwent a strange transformation, becoming at times quite faint, wheezy and spasmodic – a friend observed later that it was the voice of a ninety-year old....Most distressing of all the instinctual disruptions was that of sleep, along with a complete absence of dreams. Exhaustion combined with sleeplessness is a rare torture.'*
>
> Styron (2004, p.47) Patient

The writings of Styron (2004) capture the pain and helplessness experienced as his illness began to take hold while Kendall-Tackett (2005) expresses her feelings of disempowerment and vulnerability as a result of treatment for her depression:

> *'I'm very suspicious of a doctor who doesn't even know me coming and telling me I 'need' drugs to make me 'feel' good. ... I know that I have a problem. I want to know what caused it, what I can do to avoid it in the future, and how I can get better'*
>
> Kendall-Tackett (2005, p. 207) Patient

Wilkin in Barker (2009) understands the patient's dilemma when he argues that psychiatric mental health nursing is essentially about 'being' and 'becoming' with people who are suffering the effects of mental distress. The ability to relate to the patient is further supported in the Government's White Paper relating to Transparency in Outcomes (Department of Health, 2010) which addresses the importance of feeling cared for. The

White Paper considers that compassion, dignity and respect remain vital elements towards ensuring a positive experience of care for the patient. This statement is supported by Helm (2009) who describes her recovery as a 'pilgrimage in understanding how and what we are'. Helm (2009) considers that recovery from any mental illness may only take place with the presence of human kindness and offers a simple example of the time when a nurse washed her hair with delicate massaging fingers, and how this gentle act carried immense power towards feeling cared for

Depression following pregnancy

For the purpose of this study, a specific area of depression will be addressed – that of postnatal depression (PND), which is also known as postpartum depression (PPD). According to the literature accessed either PND or PPD may be used but both terms reflect the same condition. PPD affects approximately 13% of all new mothers (Dennis et Hodnett, 2009) and, in women with previous episodes of postpartum depression, the risk of depressive reoccurrence during the postpartum period increases to 25% (Mazure et Keita, 2006). The contributory factors in the development of PPD are both multifaceted and variable. Taylor, Glover et Kammerer (2007) observe that there is growing evidence to reveal that perinatal depression neither arises nor develops in the same way for all women. Taylor et al (2007) explain how, for some women, symptoms are triggered by childbirth whereas others experience symptoms before and after delivery. Taylor et al (2007) highlight the fact that there is a large rise in a woman's hormones during the pregnancy and cortisol in particular, in late pregnancy, reaches levels found in major melancholic depression. Following delivery, the cortisol, oestrogen and progesterone hormone levels decrease rapidly and their sudden withdrawal may result in mood changes. However Mazure et al (2006) emphasize the need to also consider the role of life stress in the postpartum period as many women struggle with the practical, financial and emotional demands created when coping with work, childcare and wider social demands such as partners and elder siblings.

PPD includes the entire first year following the birth of the baby (Beck, 1993) and manifests itself in a wide variety of symptoms including moods of sadness, anhedonia (the inability to experience pleasure), low self-esteem leading to feelings of inadequacy and inability to cope, apathy and social withdrawal, excessive emotional sensitivity, pessimistic thinking, irritability, sleep and/or appetite disturbance, impaired concentration and agitation (Kendall-Tackett, 2005). Mothers have also complained of a mental 'fogginess' that affects their ability to concentrate (Beck, 1993, 2002). Feelings of anxiety, anger and guilt are also common, as mothers are overwhelmed with the responsibilities of motherhood (Beck, 2002). Guilt is frequently confined to self-reproach as mothers criticize themselves for not loving or caring enough for their baby. At times, mothers may also harbor an enveloping fear that their lives would never return to being normal, and feel quite changed from their usual selves (Brice Pitt cited by Cox et Holden, 2007). Often the medics may think that these symptoms are just the 'baby blues' and treat the mother's concerns lightly. Gutteridge (2002) supports the medic's view to a certain degree, and argues that mild post-natal depression should be viewed as a normal adjustment to motherhood, and at a time when women need extra support in order to help them adjust to their new role. Gutteridge (2002) suggests that professionals should adopt a more qualitative view by listening to the feelings of new mothers in relation to their adjustments to motherhood, until such a time that these mothers feel comfortable within their new role. Perhaps the important link here between the writings of Barker (2009), Gutteridge (2002) and May (2007) is the role of listening to the patient and, thereafter, arriving at an accurate, client-led, 'diagnosis'.

These symptoms and fears surrounding PND are reflected first hand by the writings of Aiken (2000) who offers the reader a privileged insight into the internal struggles of the new mother. Aiken (2000) describes her desperation and resentment as her PND developed:

> *'I felt totally out of touch with the real world. My depression was setting in deeper and deeper. My self-image had hit rock bottom – I was so desperate but did not know what to do. My mood swings were intolerable and I hated and resented everyone who wasn't in my actual situation.*
> *I never knew that I was suffering from post-natal depression – it was me, my fault, my problem. I had no professional support and no hope of getting better in the foreseeable future.*
> *I then began to suffer from feelings of enormous guilt – the lack of bonding with my baby. I had bonded better with my dog and my rabbit – immediately. Why, so many months down the line, had I not bonded with my own flesh and blood? I wanted to take my child, dump her and run. I never wanted to harm her, but I wanted someone to take her away and love her like I felt I never had or could. I needed to feel young again. I was only 26 years old, yet felt old, frumpy and ugly. I had no inclination to dress up – what point was there when I would soon be covered in dribble or sick? This resulted in an even lower self-image. How could my husband still love or fancy me when I looked and felt as I did? I completely lost my sex drive. I was in desperate need of love but felt as though I no longer deserved it. I was constantly tired, moody and tearful.'*
>
> Aiken (2000, p. 25) Patient

<u>Examining the causes of PPD and its effect of relationships</u>

Following considerable research, a multifactorical etiology has been suggested which includes the importance of psychosocial variables in the development of PPD. These include stressful life events, marital conflict and the lack of social support (Cooper, 1998 cited by Dennis et al, 2009). An underlying theme that has emerged is the experience of loss. Beck (2002) identified several types of loss: the loss of self, sexuality, power in the family, personal space, intellectual ability and memory, and occupation. The final loss described by Beck (2002) was a loss of voice as mothers feared the reaction of others if they admitted how they had been struggling.

PND has wide ranging affects not only on the mother but also on her child, her partner, the family and the wider society. Kendall-Tackett (2005) explains that depressed mothers often show flat affect with their babies providing less stimulation with resultant diminished responsivity. Kendall-Tackett (2005) cites a study by Righetti-Veltema, Conne-Perreard, Bousquet et Manzano (2002) of 570 Swiss three month old babies of depressed mothers who showed less vocal or visual communication and smiled less than their non-depressed counterparts. However this study only looked at a cohort in Switzerland. It is not therefore generalisable because it is culturally related to the Swiss population.

The aforementioned study cited by Kendall-Tackett (2005) supports Bowlby's (1951) attachment model, which recognizes the importance of maternal mental health in child rearing and its subsequent impact on the emotional development of the child. The issue Bowlby (1951) fails to include in the model is the additional importance of paternal mental health on the developing needs of the child. Bowlby's (1951) study is confined to the mother-child relationship whereas more recent research has embraced PPD from a broader perspective. Bancroft et al (2008) cite an integrative review by Goodman (2004) which finds an incidence of paternal depression from 24% to 50% amongst men whose partners have been experiencing PPD, maternal depression being the strongest predictor.

One could therefore hypothesize that paternal depression could, as Bowlby (1951) suggests with maternal depression, also influence the emotional development of the child Thomas et Pollio (2002) offer a quote of a husband estranged from his wife who is suffering from PND. The quote portrays the fear, frustration and depression experienced by the partner and the subsequent risk to the stability and continuity of the family unit.

> *'How did I feel when Jane was ill? Crap, because I couldn't cope. Pushed out, because Jane devoted so much time to Daisy and less to me. Scared, because Jane had considered smothering Daisy. Afraid for my health and for Jane's stability.*
> *I lost my confidence. I lost my sex drive, as time went on, I almost lost the will to live. I found it increasingly difficult to cope. I was looking after Jane, looking after Daisy, trying to hold down a job, halfway through a five-year degree course. I subsequently stopped looking after me.'*
>
> Aiken (2000, p. 95) Partner of patient with PND

Aiken (2000) supports the belief of Cox (2005) that mental health is a family affair which could have been portrayed by the WHO theme for Mental Health Day 2005 as "Healthy parents and children" instead of "Healthy mothers and children". Such a change – by altering one word from 'mothers' to 'parents' would have assisted in focusing attention on fathers as well as mothers.

The significance of PPD to the mother, the father, the children and to relationships with the wider world, in the light of current findings, reveals that the effects of untreated PND may be felt for generations to come (Persaud, 2007).

The National Institute of Clinical Excellence (NICE, 2009) have recently recognized CBT as an effective treatment in the management of depression although NICE (2009) acknowledge that it may not be effective for all patients and do not refer specifically to PND.

The following section will provide an insight into the historical aspects of CBT, examining its relevance and role today in the treatment of depression and, subsequently, postnatal depression.

The historical component of CBT

Beck, Rush, Shaw et Emery (1979) trace the philosophical origins of cognitive therapy back to Stoic philosophers, particularly Zeno of Citium (fourth century B.C.), Chrysippus, Cicero, Seneca, Epictetus and Marcus Aurelius. Beck et al (1979) cite Epictetus' writings from the Enchindion:

> *'Men are disturbed not by things but by the views which they take of them.'*
> Beck et al (1979, p. 8)

Like Stoicism, Eastern philosophies such as Taoism and Buddhism, have emphasized that human emotions are based on ideas.

Alfred Adler (1931/1958) cited in Beck et al (1979) elaborated this interpretation of events further:

> *'We do not suffer from the shock of our experiences – the so-called trauma – but we make out of them just what suits our purposes. We are self-determined by the meaning we give to our experiences; and there is probably something of a mistake always involved when we take particular experiences as the basis of our future life. Meanings are not determined by situations, but we determine ourselves by the meanings we give to situations.'*
>
> Beck et al (1979, p. 8/9)

Today CBT is normally a time-limited therapy of six to eighteen weeks, which aims to reduce the patient's symptoms of depression through challenging negative thinking. Barker (2009) talks about the fact that the problem is not about the depression itself but, more especially, the patients' view of it and this is why CBT works. The Royal College of Psychiatrists (2010) summarizes CBT as a method that helps the person towards changing their way of thinking (cognitive) plus their actions (behaviour), ultimately helping to make the person feel emotionally better. CBT, unlike some other talking therapies, focuses on the 'here and now', looking to improve the person's current state of mind.

CBT and depression

The classic Beck model of depression centers on the 'depressive cognitive triad' (Westbrook, Kennerley et Kirk, 2007), which is a pattern of negative thoughts:

> *"**oneself** (guilt, blame, self-criticism) – 'I'm useless, inadequate ..'*
> ***the world**, and current and past experience (selective attention*
> *to the negative) – 'Nothing is worthwhile, no one cares about me ..'*
> ***the future** (pessimism, hopelessness) – 'It will always be like this,*
> *I'll never get better ..'"*

Westbrook et al (2007, p. 165)

Beck's cognitive model of depression (cited by Hawton, Salkovskis, Kirk et Clark, 2006) is illustrated in Appendix 1 along with the common maintenance processes in Appendix 2 (Westbrook et al, 2007).

Cognitive behavioural therapy focuses on identifying and changing the pattern of disturbed cognition through creating awareness either by thought records or behavioural activation. It bases itself around the three levels of belief identified by Beck (1995) being core beliefs, underlying dysfunctional assumptions and automatic thoughts. Beck J. (1995) considers that all levels of belief are interconnected with emotion, psychological factors and behaviour.

Theoretically, Beck et al (2009) considered that the correction of distressful or dysfunctional emotional states occurs through the distancing process, which may be bought about by various approaches being cognitive, behavioural and pharmacological. Peden, Rayens, Hall et Grant (2005) used the CBT approach in a study to reduce negative thinking and depressive symptoms in low-income single mothers. Cognitive behavioural strategies were taught to help the participants alter their thoughts, feelings and behaviours. One of the strategies involved the interruption of negative thinking followed by the insertion of a positive thought which is referred to as an affirmation. The findings of the study revealed that, compared with the control group, women who received the CBT intervention had a greater decrease in depressive symptoms and negative thinking; these beneficial effects were maintained over a six month period. However, the limitation of the study was that only 63% of the experimental group and 70% of the control group completed both follow-up interviews; the group was also restricted to low-income single mothers who received three interviews at home by the same interviewer. This familiarity with the interviewer also presented the risk of the 'Hawthorne effect' (Gerrish et Lacey, 2010) taking place whereby the involvement in the interview itself may change the views or perceptions of the participants.

Gordon (Gordon et Tobin, 1991) became the first nurse researcher to design a cognitive behavioural group intervention to treat depression in women, which was based on Beck's 1967 model. This programme has been widely used clinically and validated empirically (Gordon et al, 1991; Maynard, 1993) as a means to assist people to change their thinking styles. The programme promoted group therapy as a means to provide opportunities for helpful social comparisons and the sharing of negative information about the self (Yalom, 1985). The benefits experienced from such group work are reflected in a quote from a participant:

> *'For me, to know that they cared was powerful. Here were 'other people' who didn't ridicule me for my fears or my behaviour. They wanted to listen to my story and it felt strangely safe for me to share it.'*
>
> Gilbert (2006, p. 374)

The group aimed to promote awareness in the women of their real feelings helping them to control their negative thoughts and behaviour which were maintaining their depression. The bonding with other women and the encouragement of the group was acknowledged as a strong factor in helping bring about positive change. The workbook however is written for the American woman and has not been subject to research. The reason for quoting this programme is because it is referred to frequently in research articles and maintains similarities with present day groups based on CBT techniques.

Currently research has involved studies in a group and in an individual setting. Craig, Judd et Hodgins (2005) examined the effectiveness of therapeutic groupwork using cognitive behavioural strategies by community health workers for women with PND. Fourteen women completed the programme which revealed a significant reduction in mean anxiety and depressive system scores after a nine week group programme. However the two main limitations of this pilot study were the small sample size and the lack of a control group for comparison. Davies et Jasper (2004) conducted a similar group to Craig et al (2005) with the programme being based on the CBT model using behavioural interventions and restructuring faulty cognitions. It consisted of twelve weekly sessions with eight group members. The facilitation of the group was by a health visitor (HV) with a registered mental health nursing qualification and a family centre worker. It was noted by Davies et al (2004) that the strengths of using CBT are that it can facilitate good working relationships with clients due to its positive outlook and active client participation and may therefore be applied in many different settings with different client groups; also being delivered by professionals with varying degrees of expertise (Tarrier, Wells et Haddock, 1998). The study by Craig et al (2004) is a good example of this in the use of community health workers in rural Victoria, Australia compared to Davies et al (2004) group using a HV and family centre worker. The results of the Davies et al (2004) study were positive in that the goals of the group were achieved. However, limitations existed in the small sample size and the lack of a control group.

Two larger studies involving home visits took place in France and the U.K. respectively. Chabrol, Teissedre, Saint-Jean, Teisseyre, Roge et Mullet (2002) involved 859 french women in a study to assess the prevention and treatment of postnatal depression using a cognitive behavioural programme. Therapy was offered by trained therapists during five to eight weekly home visits. However findings from this study revealed that prevention intervention did not have a significantly beneficial clinical effect so that it became necessary to create a treatment intervention for those who went on to develop PND. Researchers went on to discover that depressive symptoms were reduced in the group who were offered home-based treatment. Chabrol et al (2002) became aware that the brief intervention in the prevention programme had the advantage of developing a collaborative relationship with the therapist, which facilitated the acceptability and effectiveness of the treatment should depression occur and treatment be required. Limitations to the study involved a lack of follow-up resulting in a gap in information available as regards the efficacy of the treatment when looking at relapse and the reoccurrence of the woman's depression. The latter study in the U.K. by Morrell, Slade, Warner, Paley, Dixon, Walters, Brugha, Barkham, Parry et Nicholl (2009) involved 595 women in assessing the clinical effectiveness of HV training in psychologically informed approaches (CBT or person-centred therapy) for depression in postnatal women through a pragmatic cluster randomized trial. The intervention involved suitably trained HVs identifying depressive symptoms at six to eight weeks postnatally using the Edinburgh Postnatal Depression Scale (see Appendix 4) and thereafter providing CBT or person-centred therapy for an hour a week for eight weeks. Results of the Morrell et al (2009) study revealed that the benefits for all women receiving therapy were maintained at twelve months postnatally regardless of the psychological approach used. Limitations included a potential source of bias due to women both in the control group and intervention group being prescribed antidepressants. This large trial of treatment for PND offers new evidence to indicate that training in psychologically informed approaches can be recommended for HVs to enable them to identify and offer therapy to mothers who are suffering from PND.

The literature search, which was conducted in order to identify examples of CBT group work with PND women, revealed few examples of such groups that had been evaluated and written up for publication. This discovery becomes instrumental in the identification of existing gaps in knowledge.

Conclusion

The literature review has revealed the benefits of cognitive behavioural therapy offered to depressed persons and postnatally depressed mothers in both a one to one and group setting. At the same time the need for a family approach plus interagency working has been highlighted. However, a literature search to locate other like-minded groups revealed no similar project in the United Kingdom. Results from nine trials involving 956 women in Canada found that both psychosocial (e.g. peer support, non-directive counseling) and psychological (e.g. cognitive behavioural therapy and interpersonal psychotherapy) interventions appear to be effective in reducing symptoms of postnatal depression although the long-term benefits remain unknown (Dennis et al, 2009). In this research article the authors offered the following as one of the implications for further research:

> "Important postpartum treatment barriers such as stigma, transportation childcare, and availability of services and high attrition rates found in some group or clinic-based postpartum depression treatment studies, suggest the **need for the evaluation of novel treatment modalities**, including those provided by telephone or internet"
>
> Dennis et al (2009 p 10-11)

Ugarrize (2004) working in U.S.A. also highlighted one of the problems of postpartum women attending for group therapy as being their inability to get to therapy due to childcare. She also acknowledged that the use of cognitive restructuring in group work produced lower depression scores post group.

Meager et Milgrom (1996) in Australia reported on a pilot evaluation of a treatment programme using educational, social support and cognitive behavioural components and **concluded that a cognitive behavioural group programme might be effective as a treatment for depression in the postpartum period but considered that further studies were required.**

The above research articles identify the following gaps in knowledge:

1 there is no mirror image group to the one that is being evaluated for this study in the United Kingdom;

2 the long term benefits of psychosocial and psychological interventions are unknown (Dennis et al, 2009);

3 the need for the evaluation of novel treatment modalities is recognized by Dennis et al (2009);

4 the use of cognitive restructuring in both group (Ugarrize, 2004) and individual work (Chabrol et al, 2002) has been recognized to lower depression scores postgroup and to be reasonably well-accepted and efficacious.

Aims of the study

The short-term aims are to identify the benefits experienced by mothers suffering with postnatal depression following their attendance at a support group, incorporating within its sessions the use of compassionate-focused cognitive behavioural therapy techniques. This will be carried out in the form of a retrospective evaluation, identifying common themes running through the anonymous questionnaires completed by the participants at the end of the six week group sessions.

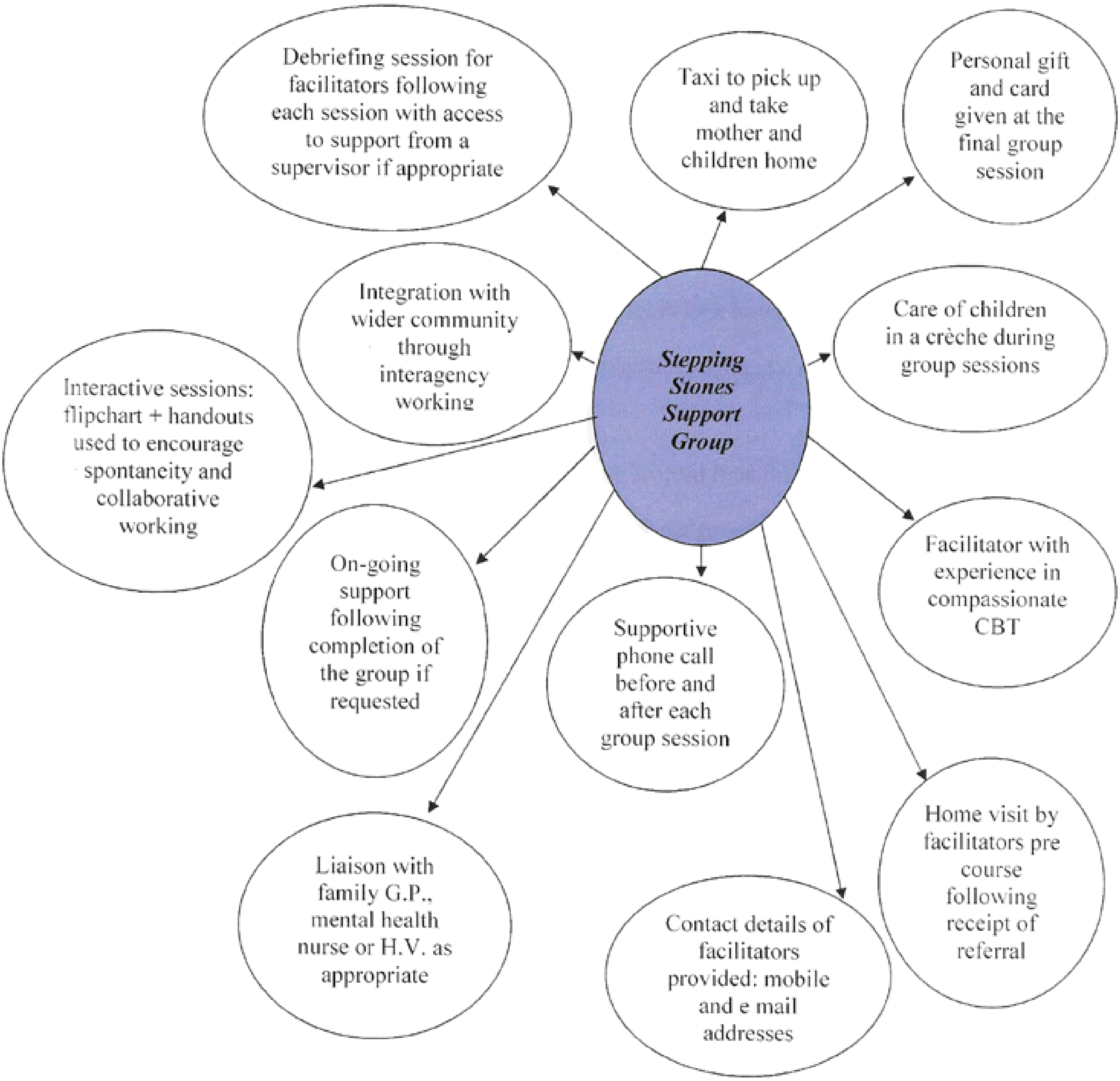
The long-term aim is to encourage the setting up of such support groups in other areas of the country with appropriately trained personnel.

Objective

The objective will be to examine from a holistic perspective, the integral running of the support group, in order to discuss and offer evidence based reasons to support its organization and content towards the treatment of postnatal depression.

The criteria adopted for the running of the support group is illustrated in Diagram 1 (p.22) and the compassionate-focussed approach used in Diagram 2 (p.65).

Diagram 1: Criteria adopted for the SSS Group



Methodology

The methodology aims to show the appropriateness of the techniques used to gather data along with the methodological approaches that have been employed (Hart, 2009). There are two methodological approaches or paradigms, the scientific or quantitative approach, and the interpretative or qualitative approach (Gerrish et al, 2010).

This retrospective study in the form of an evaluation embraces the qualitative paradigm and, although not a piece of research, it remains helpful to look historically at the development of the research process which has implications upon any study involving the general public.

The varying approaches to the research process have evolved from the three main philosophical themes that influenced the search for knowledge and ultimately the search for truth (McKenna, 2009). These themes include rationalism (reason), empiricism (sensory experience) and historicism (life experiences, values and beliefs) from which two schools of thought developed; these were namely the positivist and the anti-positivist perspectives. The positivist perspective arose from the French philosopher, Auguste Comte (1798-1857), who used the term 'positive knowledge' to describe the use of scientific methods to solve human problems and to distinguish this approach from 'negative knowledge', which Comte believed was a result of metaphysical thinking or abstract general reasoning (Haralambos et Holborn, 2008). As a result of this viewpoint, reflection and intuition were rejected by positivists as subjective approaches to knowledge development. Today it is the positivist approach that remains at the heart of quantitative research although its boundaries are less strict (Bryman, 2008) In contrast, the anti-positivist approach is influenced by historicism that provides evidence from people's experiences, beliefs and other mental processes (McKenna, 2009). This type of interpretative and inductive approach is more familiar to qualitative research whereas a critical and deductive approach is familiar to quantitative research.

Deductivist, objectivist and positivist approaches in quantitative research

Deductivist reasoning is taking a known idea or theory and applying it to a situation (Teatheredge, 2007). The investigator may start with general ideas and develop a theory and testable hypotheses from it to be tested by data (deduction). The Greek philosopher Plato (428-348 BC) argued that it was through logical thought or deduction that one could learn objectively about reality (Cresswell, 2009). The choice of approach has a long history of debate in the philosophy of science, and in the social sciences. Positivism is the dominant philosophy underlying quantitative scientific methods and aims to discover laws using quantitative methods and emphasizes positive facts. As far back as Sir Isaac Newton (1642-1727) sociological thinkers believed society could be analysed scientifically. Early positivists such as Emile Durkheim (1858-1917) considered that, by adopting a 'scientific' methodology, objectivity was attainable. However Max Weber (1864-1727) did not consider that complete value-freedom was possible although he believed that the researcher could be objective (Haralambos et al, 2008). Positivism assumes that phenomena are measurable using the deductive principles of the scientific method. It also assumes that, like matter, human behaviour is a reaction to external stimuli and that it is possible to observe and measure it using the principle of the natural (e.g. biology) and physical (e.g. chemistry and physics) scientist, and thereby establish a reliable and valid body of knowledge about its operation (Gerrish et al, 2010). Positivist traditions shape many of the methods of research on health and health care, and the way the research instruments are administered. For example, interviews are standardized and structured in order to minimize the influence of the instrument and the interviewer on the respondent. Quantitative information is often numerical in nature being the result of a formal measurement, in order to encourage objectivity and reduce influencing factors (Haralambos et al, 2008)

Bowling (2005) states that scientific research implies the exercise of objectivity from the inception of the research idea, the design of the study, the methods used, the process of carrying it out and the analysis i.e. the interpretation of the research results. Thomas et Mohan (2007) clarify that, by adopting a contrastive approach to data analysis, there is more likelihood that the empirical analysis undertaken is objective and fair and thus has more credibility. The produced research will also be able to stand up to scrutiny by dealing with rival ideas.

Inductivist, interpretative and constructionist approaches in qualitative research

In inductive reasoning the investigator begins by collecting data and building up observations for testing from them. These observations serve to formulate more general statements and thereby develop testable hypotheses for further testing on the basis of further observations (Silverman, 2006).

Aristotle (384-322 BC) emphasized in his epistemology that knowledge advances by induction or observation of the world and in turn this leads on to the construction of theory or logical thought, known as deduction. Aristotle's acknowledgment of induction forms the basis of the qualitative model (Prasad, 2005).

The qualitative model aims to describe social systems, social relations, or social events, thereby providing background information about the issue in question and stimulating explanation (Creswell, 2009). The analysis of qualitative data does not rely on numerical deduction but is interpreted by means of analysing an observed behaviour, and/or data contained in text, field notes or transcripts. Therefore, qualitative research is exploratory in nature and seeks to identify patterns of similarity through the examination of specific instances and events in their natural setting (Polit et Beck, 2005). However qualitative research is not competitive with quantitative research. Silverman (2006) views their relationship as a division of labour in which qualitative researchers seek to answer 'how' and 'what' questions and then pass on their findings so that the causes and outputs of the phenomena identified ('why') questions can be studied by their quantitative colleagues.

Harnassing the best from the quantitative and qualitative approaches to research

Gomm (2008) cites Oakley (2000) who questions whether research would be better off without the language of 'quantitative' and 'qualitative' which, in view of the developing overlap between the two approaches, presents as a reasonable hypothesis. Bryman (2008) goes on to explain that, whilst there are many differences between the research strategies, there are many examples of research that transcend these differences. Bryman (2008) continues by quoting types of qualitative research that contain elements of the natural science model plus quantitative data that contain elements of interpretivism which leads Robson (2002) to postulate that the two approaches may have developed a certain fluidity between them Another interesting development towards the merging of the two strategies may be observed in the approach to analyse the other i.e. a qualitative research approach to quantitative research plus a quantitative research approach to qualitative research.

The chosen empirical study is qualitative in nature due to the combination of the aims of the study, research strategy and data collection technique (Biggam, 2010).

The aim of the retrospective evaluation is to identify the perceived benefits to postnatally depressed mothers attending a support group based on CFCBT. In order to achieve this aim the research strategy adopted the case study approach whereby qualitative data, collected retrospectively through the use of questionnaires, was examined adopting a thematic analysis approach (Gerrish et al, 2010).

The group was originally initiated by a charity which invited representatives of the NHS to work with them in addressing the needs of women suffering from postnatal depression. The framework for the group sessions was created by two qualified NHS employees, one who was undergoing further training to become a CBT therapist and the second with previous counselling experience. The framework relied heavily on Milgrom, Martin et Negri's (2006) work relating to community groups based on CBT principles for postnatally depressed women in addition to the compassion-focussed work of Gilbert (2006).

Stepping Stones Support Group (SSSG) Framework

Before the commencement of the group, the participant received an explanatory letter about the SSSG (see appendix 7) in addition to a home visit from one of the facilitators. The home visit served to establish if the group was suitable to the needs of the client through the sharing of information and mutual collaboration. This home visit was then followed up with a phone call from the charity welcoming them on to the forthcoming group.

The framework of the group was composed of the following six sessions:

1. 'Welcome'

   Icebreaker; Supporting each other; Pregnancy, birth and now; What women say; What is PND? What can help; Homework and handouts.

2. 'Time for Mom'

   Feelings, behaviour, thinking (with role play by facilitators); The depressive spiral; Pleasant activities and mood; Homework and handouts.

3. 'Stress busters'

   High stress times; Recognising early warning signs of tension; Coping with tension; Relaxation; Portable stress busters; Homework and handouts.

4. 'Being firm but kind'

   Assertiveness skills with role play (by facilitators); Communication styles (passive, assertive, indirect, aggressive); Self-esteem; Homework and handouts.

5. 'Being ourselves'

   Being kind to ourselves; our survival bucket; our positives (use of positive data log); homework and handouts.

6. 'Looking back, moving forward'

   Use of flashcards; Overview of previous sessions; Preparation for moving forward; Future support and contacts; Completion of Evaluation forms; Group hug and parting gift to each participant.

The decision to use the evaluation forms as part of a retrospective study was taken with the overall aim of producing evidence to support the continuation of the PND group work adopting the compassionate-focussed CBT approach.

A qualitative approach has been chosen as the methodological style due to the presence of particular features in the retrospective evaluative study, which include a focus on human experience and the production of descriptive data as a result of an open-style questionnaire (Gerrish et al, 2010). Munhall (2001) cited by Rolfe (2006) considers that such features reflect the characteristics of a qualitative study. Rolfe (2006) however argues that, although the term ‘qualitative research’ may be used to describe methods of data collection, there is no research paradigm or philosophy, which embraces the full diversity of ‘non-qualitative’ methodologies and suggests that each study should be justified on its own merits.

Ethical considerations

The World Medical Association Declaration of Helsinki (2008) is a statement of ethical principles for medical research involving human subjects, which includes research on identifiable human material and data. In relation to this study, whilst the methodology has followed a research process, the study in question remains evaluative in nature and adheres to the guidelines listed by the National Patient Safety agency (NPSA, 2007). The criteria for a service evaluation project are included in appendix 5; however the most relevant points concern the issues with **current care** rather than a **new treatment**. This retrospective evaluation looks at a different approach to the treatment of PND via compassionate-focussed CBT rather than a new treatment. In line with the NPSA (2007), the study also measures a current service without reference to a standard and analyses existing data which includes the use of an anonymous questionnaire. The Vice-Chairman of the Anglia Ruskin Research Ethics Committee (REC) informed the author that ethical approval was not required as the retrospective evaluation did not take place on NHS property and was also based on the analysis of anonymous questionnaires. The NHS Research Management and Governance Facilitator acknowledged the aforementioned decision (see Appendix 6).

Currently the five research ethic principles include confidentiality, coercion, consent, care and communication (Rudestham et Newton, 2007). Within the NHS there are six ethical principles that nurses must observe when undertaking research. These are beneficence, non-malfeasance, fidelity, justice, veracity and confidentiality which also need to be upheld within the Nursing and Midwifery Council (2008) in order to ensure that the patients are able to trust nursing professionals with their health and well-being and that benevolence (the greatest good for the least harm) is maintained (Beauchamp et Childress, 2009). It is important, even in a retrospective evaluative study that these principles are adhered to. For example, in spite of the questionnaires being anonymous, the fact that they may contain sensitive information highlights the need to store the collected data on a removable device, not on the hard drive and to keep the device inside a locked filing cabinet within a locked room with the key being kept in a place of safety. It is also the duty of the person carrying out the study to realize the potential of the evaluation by developing a deep and real illustration of service provision. This deep and real illustration constitutes an ethical issue due to the dilemma of deciding what to incorporate or reject, what to emphasize and ultimately what to disclose in the data collected (Mauthner, Birch, Jessop et Miller, 2008). The researcher is often alone with the data and, in this retrospective evaluation, the author has been the only one involved in its analysis. Glucksmann (1994) cited by Mauthner et al (2008) considers that ethnical considerations enter equally, if not more, into the stage of processing the data and sees the research relationship as one that is endowed with issues of trust.

> *'Each researcher is left on trust to draw the difficult line between interpreting the data in terms of its relevance to her research question as opposed to twisting it in a way that amounted to a misrepresentation of what was said'*
>
> Glucksmann (1994) cited by Mauthner et al (2008, p.129)

The retrospective evaluation in question will be conveyed in the formulation of clear and accurate recommendations, which will ultimately be communicated to the relevant bodies of interest. Such intention to care will prove instrumental in safeguarding against the bias that has been associated with traditional professionally dominated methods of healthcare evaluation (Hall, 2004). This bias may also be challenged through user involvement in research (or in this instance, evaluation), which Beresford (2002) considers should be in equal association with service user organizations and movements.

Research Process

Sampling technique

Sample selection in qualitative research is important even thought the object of the study is not to generate statistically significant findings (Smith, Sinclair, Raine et Reeves, 2005). In this retrospective evaluation, the sample seeks to obtain insights into the benefits to postnatally depressed women following attendance at a compassionate-focussed CBT group instead of a sample that seeks to represent the whole population.

A sample is the segment of the population that is selected for investigation. The methods used for such selection to take place may be based on a probability or a non-probability approach (Bryman, 2008).

Probability sampling, also known as random sampling, is where it is possible to specify the probability that any person or unit will be included in the sample (O'Leary, 2009). The aim of probability sampling is to keep sampling error to a minimum. Non-probability sampling (NPS) or non-random sampling on the other hand relates to when a sample has not been selected using a random selection method and conveys that some units of the population are more likely to be selected than others (Bryman, 2008). In the case of this retrospective evaluation the type of sampling was non-probability with the following inclusion and exclusion criteria for the Stepping Stones Support group:

- women whose EPDS totaled 12 or more (see appendix 4);
- women who have a child below the age of five years;
- all women regardless of race, religion or marital status;
- women who live within the catchment area of the charity.

Exclusion of women would be those who do not fulfill the inclusion criteria.

Non-probability sampling (NPS) covers a wide range of sampling strategies, the main types being convenience, snowball and quota sampling (Gomm, 2008). NPS is commonly used, as in this study, with small-scale surveys and is also chosen where a probability sample would not be feasible such as where resources are limited. However Robson (2002) warns that the accuracy of NPS relies heavily on the skill and experience of those involved. The specific type of NPS adopted by the author is classified as convenience sampling which involves the selection of a sample with a particular purpose in mind – in this case the response of postnatally depressed women to group work using CFCBT techniques. The resulting data used for the retrospective evaluation may not allow for definitive findings to be granted due to the problem of generalization. However such data may serve to act as a springboard for research in the future or otherwise help to forge links with existing findings in an area (Bryman, 2008). The clients were selected through referrals via agencies that were competent at recognizing the signs of postnatal depression in women.

Data Collection

The questionnaire was designed by the charity with whom the group work was conducted and had previously been used to evaluate the responses of participants attending other groups that were not specifically focused on the treatment of postnatal depression.

As the data had already been collected through the means of anonymous questionnaires (see Appendix 3) and had not been analyzed, it seemed more purposeful at this stage to carry out a retrospective evaluative study. There is a host of ethical issues relating to the use of questionnaires and, although in this study informed consent was not relevant, questionnaire studies need to at least guarantee confidentiality (Polit et al, 2005).

In this retrospective evaluation, the use of the anonymous questionnaires appeared to be the most appropriate method of data collection available in order to access the required information. Gerrish et al (2010) comment that such anonymity may also allow the participant to feel more ready to provide information which is supported by Oppenheim (2009) who considers that open questions allow the participant both freedom of expression and spontaneity in the answers. In the SSS group anonymity was preserved through the collection of the unnamed questionnaires in a posting box which was provided for participants to use once the questionnaire had been completed. These questionnaires were completed and collected during the final session of a six week course which was attended by six to eight participants. Oppenheim (2009) however warns of contamination in group-administered questionnaires due to the danger of copying, talking or asking questions. Smith et al (2005) alert the researcher to 'acquiescence bias' where patients have a tendency to agree regardless of the question intent. However Smith et al (2005) state that acquiescence may be minimised by balancing positively and negatively phrased questions. In the evaluation form (appendix 3) it may be noted that there are four general questions (1,5,7,8); two positive questions (2,4); and two negative questions (3,6) offering an reasonable balance of general, positive and negative questions to the participant and in this way hopefully reducing acquiescence bias.

For ease of reference, the questions on the evaluation form are listed below under their appropriate headings:

General questions:

Question 1: I came to this Support Group because ...

Question 5: I would have liked to have done more about ...

Question 7: Now the course if finishing I will ...

Questions 8: Is there anything else you would like to say?

Positive questions:

Question 2: The best things about coming were...

Question 4: Coming to the course has helped me...

Negative questions:

Question 3: The worst things were ...

Question 6: For the next course it would be better if ...

However, in the event of future research in place of a retrospective evaluation, greater insight could be accessed through the use of individual interviews.

Data Analysis

> "All meanings, we know, depend on the key of interpretation"
>
> George Eliot (1819-1880)

The strength of qualitative research is to accurately represent the experiences of the participants (Streubert et Carpenter, 2010). It is concerned with the construction of meaning and the presentation of the particular participants' reality than with traditional notions of validity and reliability, however the methodology of this form of research has been criticized for its lack of rigor. Burns et Grove (2005) argue that this criticism has occurred because of attempts to judge rigor using rules developed to judge quantitative research but, nevertheless, Robson (2002) goes on to warn the analyst that, in order to come up with trustworthy answers, the analysis needs to treat the evidence fairly and without bias ruling out any alternative interpretations. Robson (2002) states that this advice applies both to qualitative and quantitative data, the major task being to find answers to the research question.

For this study, qualitative data has been collected in the form of questionnaires which will be interpreted using a methodical and organized approach. In this way, it is intended that complex raw data will be transformed into rich and meaningful understanding within a logical and systematic framework. O'Leary (2005) states that the best way to make this journey from raw qualitative data to meaningful understanding is through data immersion in order to allow for the discovery of themes plus the interpretation of the implication of these themes.

During the analysis of data, three dominant processes take place: reflection, comparison and creativity, the latter being imperative as there is no one right way to make meaning of the data (Gerrish et al, 2010). The inductive process is adopted in order that a map may be created while the data is being worked through (O'Leary, 2005). However Oppenheim (2009) discusses the problem loss of information during this process of analysis. Oppenheim (2009) observes that the number of coding categories (in this study 13 themes were identified which were further refined into three topics) cannot be unlimited and states that the question is not how to avoid loss of information but rather at what stage the inevitable loss of some information will cause the least bias.

Collaizzi's (1978) 7 stage process (Law, 2010) was used as a reference document in order to carry out the data analysis. For the purpose of this study the response to each of the eight questions (appendix 3) was written down verbatim so that for each question there were 30 responses from the 30 participants taking part in the SSS groups. In total 240 responses (i.e. 30 responses x 8 questions) were written down. From these responses, following reading and rereading, 13 'themes' emerged which conveyed frequently used words or expressions in the collected data. These 13 themes were then classified into headings or 'topics' in order to further streamline the areas which reflected the thoughts and feelings of the participants attending the SSS group (table 1, p52). This process was very lengthy and is acknowledged by Oppenheim (2009) to be one of the disadvantages of this type of data collection. The process involved comparison and creativity in order to establish common threads in the data (Gerrish et al, 2010) and, although time consuming, was also exciting, fascinating and rewarding as rich data evolved to provide the necessary evidence to demonstrate the benefits gained to participants attending the

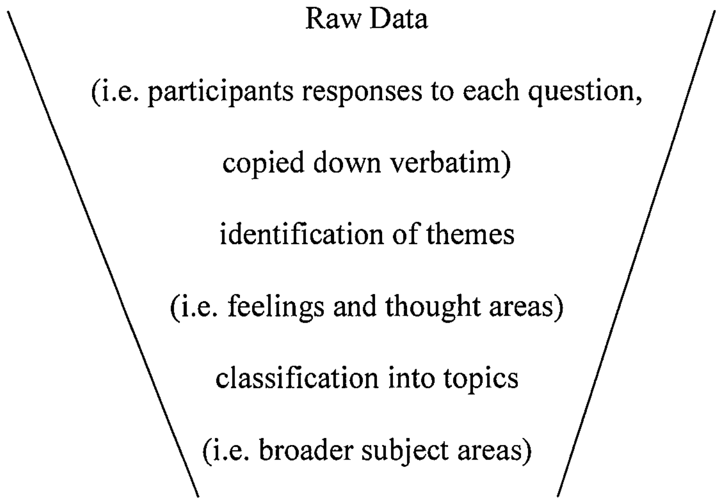
SSS group adopting compassionate-focused CBT techniques.

However the limitations of such results are clearly that of individual interpretation as, in the event of another individual analyzing the same data collected from the 30 questionnaires, it is possible that alternative themes and topic areas are identified. It is for this reason that the use of direct quotes from the participants' responses to the anonymous questionnaires has been adopted as part of the methodology in an effort to reduce the risks of bias and inconsistency (Oppenheim, 2009).

Results

For the purpose of this evaluative study, anonymous qualitative questionnaires (see appendix 3) collected over a 24 month period and involving five groups of postnatally depressed mothers, were examined retrospectively. The mothers came from different cultural and economic backgrounds with differing social support in the home environment which promotes the transferability of the data collected (Bryman, 2008). Reference was made to two thematic studies (Park, Butcher et Maas, 2004; and O'Leary, 2004) as a guide to creating mapping diagrams. These studies are concerned with completely different topic areas in order that no prejudice of bias may be brought into the current study. O'Leary (2004) considers that the mapping process is one way of dealing with what may appear to be an unwieldy raw data set and refers to two differing approaches: the deductive and inductive approach. O'Leary (2004) explains that in the deductive approach data is uncovered to support a predetermined theory, which may have arisen from engagement with the literature or insights while collecting the data; or, alternatively, in the inductive approach where data is explored without a predetermined theory in order to discover themes emerging from the data. Strauss et Corbin (1998) cited by O'Leary (2004) refer to the inductive process as a method whereby theory is obtained from data systematically gathered and analyzed through the research process. For the purpose of this study the inductive approach was adopted whereby themes and topic areas emerged as the data was being worked through. However the fact that the author had been exposed to certain writings in the literature review may have resulted in the analysis of the data also having an element of the deductive approach. For example, the author was able to recognize similarities between the literature in the review and the participants' responses to the questions in the questionnaire (appendix 3) in relation to the symptoms of depression such as the loss of voice.

In total 30 questionnaires were collected and the participants' answers to the eight questions were copied down verbatim revealing 240 responses. Out of these 240 responses, 13 **themes** were identified relating to feelings and thoughts. These themes were then further channelled into 3 broader subject areas classified as **topics**. The process is shown diagrammatically below:



Raw Data

(i.e. participants responses to each question,

copied down verbatim)

identification of themes

(i.e. feelings and thought areas)

classification into topics

(i.e. broader subject areas)

Funnelling down towards meaning (O'Leary, 2004)

Each of the three topics is presented in table one (see p. 52) with the accompanying themes and number of supporting responses. Percentages are also provided in the final column relating to the frequency of usage of the themes in the thirty questionnaires collected. Samples of the responses have been used in Maps A and B (see pages 53 and 54 respectively) in order to illustrate some of the rich data that had been collected for the retrospective evaluation.

The results produced in table 1 (p.52) identify low self-esteem, positive feelings and learning as the three topics emerging from the data. These three topic areas and their associated themes are discussed in turn with the use of quotes in order that the results remain personalized and not distorted by the author's interpretation. Gomm (2008) warns that thematic analysis is vulnerable to criticism whereby the analysis may reveal more about what was in the mind of the analyst than what was in the mind of the participant. The use of direct quotes will therefore help to reduce the risks of inconsistency and bias (Oppenheim, 2009). The quotes contain a rich use of words which reflect the power of qualitative data (Barker, 2009) providing a deeper insight into this retrospective evaluation and helping to answer the 'how' and 'what' questions that are common in qualitative research (Silverman, 2006).

Einstein reflects the struggle to present meaningful data in the following statement:

> *"Not everything that can be counted counts, and*
> *not everything that counts can be counted."*
>
> Albert Einstein (1879-1955)

The topic headings of low self-esteem, positive feelings and learning (table 1, p52) were identified by the author from the themes that had arisen from the responses of the clients. Gomm (2008) acknowledges that the identification of certain themes may be inspired by a set of theoretical ideas already espoused by the analyst. In this respect one could assume that the author has been affected in the choice of themes and topics theoretically by her exposure to the literature involved in this study and experientially through the practical running of the SSS group which involves direct contact with the postnatally depressed mothers.

Silverman (2006) views the primary issue in producing results as the generation of data which offers an authentic insight into people's fears, needs and learning. The data for this study was the result of five SSS groups which each followed a six week programme (refer p.28) beginning with issues of struggle and pain in the early weeks and moving on, in the latter weeks, to learning methods and approaches to cope with painful thoughts and emotions plus difficult situations. The data, collected from the anonymous questionnaires at the end of each course, has been presented by the use of direct quotes in an effort to preserve the rich meaning behind the feedback (Barker, 2009). It is hoped, by using this method of presentation, that the reader will be able to develop an awareness of the participant's slow progression towards recovery from postnatal depression. For the purpose of this evaluative study, the responses to the questions will be categorized under participant 1 (P1) to participant 30 (P30) with the code of the pertinent question being placed in brackets following the quotes, i.e. question 1 (Q1) to question 8 (Q8) in order to offer further clarity as to the subject area involved in the questionnaire (appendix 3).

The results commence with the first topic area relating to low self-esteem.

Low Self-Esteem

Many of the women attending the SSS group struggled with feelings of loneliness, depression and tearfulness; fear of speaking out and feelings of anxiety, worry and self-failure. These quotes are taken from the responses to the following questions:

Question 1 (Q1): I came to this support group because ......
Question 3 (Q3): The worst things were ...

and reflect the mothers' difficulties in coping with their changing moods, their relationships and their negative self-image.

P2, P6, P26 wished to meet others who felt the same as them:

> *P2: "...I wanted to be/meet with other women/mothers who felt the same and would not judge me on my views or things I had gone through." (Q1)*
>
> *P6: "...I thought it would be a good chance for me to meet new people that felt the same as me."(Q1)*
>
> *P26: "...I thought it would be good to meet people in similar situations as me ...in regard to mental health."(Q1)*

P9, P10, P11, P14, P15, P16, P18, P21, P22, P23 had difficulty in talking in a group and sharing their problems, or listening to other's problems

> *P9: "...acknowledging that I am in trouble and need help. opening up some of the difficult issues ...(Q3)*
>
> *P10: "...Its difficult to share my problems and feelings with a room of strangers. On my bad days I was unable to see how this could help me."(Q3)*
>
> *P11: "...sharing my problems with others but then felt quite comfortable, didn't know how people were going to feel about me."(Q3)*
>
> *P14: "...I was nervous about talking about things in a group."(Q3)*
>
> *P15: "...having to speak in a group."(Q3)*

> *P16: "...having to tell the truth."(Q3)*
>
> *P17: "...listening to other's pain."(Q3)*
>
> *P18: "...It was hard at first to open up but everyone's the same as me and made me feel very comfortable."(Q3)*
>
> *P21: "...found it hard to talk out in the first session but over the weeks got more confident."(Q3)*
>
> *P22: "...being in a group, it is hard if you are quiet."(Q3)*
>
> *P23: "...speaking in front of strangers, crying in front of strangers."(Q3)*

P11, P16, P18, P19, P21, P22, P23, P27, P28, P30 felt low, lonely, isolated, tearful, anxious, stressed and depressed with up and down moods:

> *P5: "...I needed to talk."(Q1)*
>
> *P8: "...I want to feel happier as a person and a mother."(Q1)*
>
> *P11: "I felt lonely and isolated, tearful and of low mood and, most of the time, very depressed."(Q1)*
>
> *P16: "I was very stressed and very down."(Q1)*
>
> *P18: "...feeling very low and isolated."(Q1)*
>
> *P19: "My moods were very up and down. I was very tearful and took a lot out on my partner."(Q1)*
>
> *P19: "...saying a positive about myself."(Q3)*
>
> *P21: "I felt really low, constantly worrying, crying, feeling like a failure."(Q1)*
>
> *P22: "...I am anxious and felt very down."(Q1)*
>
> *P23: "... I was feeling very low emotionally..."(Q1)*
>
> *P27: "...I was very depressed and felt like I couldn't cope."(Q1)*
>
> *P28: "...I was feeling very low and isolated."(Q1)*
>
> *P30: "...I was feeling low and needed support."(Q1)*

P8, P12, P13, P28 were afraid or reluctant to come to the group:

> *P8: "...the first time meeting people"(Q3)*
>
> *P12: "...... being scared about coming at first." (Q3)*
>
> *P13: "...I was very reluctant to come but I was pleasantly surprised by the preparation and effort put in by everybody."(Q1)*
>
> *P28: "...mastering the courage to attend the first session, sometimes feeling that my problems were insignificant."(Q3)*

Following on from the participants struggle to cope with attending the SSS group, to cope with difficulties around self-expression and to manage their low moods, came the emergence of a more contented and compassionate-self revealed under 'positive feelings'.

Positive Feelings

The expression of gratitude for the group experience was a frequent feedback from the questionnaires in addition to the thought of not being alone in their feelings; feeling happy about oneself, being kind to oneself and feeling cared for. These quotes are taken from responses to the following questions:

Question 2 (Q2): The best things about coming were ...
Question 4 (Q4): Coming to the course has helped me to ...
Question 8 (Q8): Is there anything else you want to say?

P1, P8, P28 expressed their ability to open up and not hide their feelings anymore:

> *P1: "...... come to terms with my feelings and not hiding them anymore."(Q4)*
>
> *P8: "... being able to express my feelings confidentially."(Q2)*
>
> *P28: "...a safe and secure environment to speak about how I'm feeling."(Q2)*

P2 and P26 appreciated the feeling of being cared for:

> *P2: "Thank you for the group leaders, it's nice when someone actually cares about our feelings, makes us feel worthy." (Q8)*

> *P26: "……meeting new people. The openness and warmness of the group." (Q2)*

P3 enjoyed meeting new people, making friends and feeling supported:

> *P3: "……meeting new people; feeling supported; the homework tasks; realizing I'm not alone and things could be much worse; taxi service; crèche; the co-ordinators had actual experiences of PND and were open and honest about it, a lovely group of people; a feeling of gratitude and relief which was totally unexpected; cake!" (Q2)*

P8, P11, P28 enjoyed meeting people who felt the same as themselves:

> *P8: "...meeting people who feel the same." (Q2)*

> *P11: "...meeting new people and realizing that I am not the only one who has problems..." (Q2)*

> *P28: "……meeting others in similar situations." (Q2)*

P9, P15, P16, P17, P21, P28, P29 expressed appreciation for the course:

> *P9: "Thanks from the bottom of my heart to ... (names of the facilitators) and to 'us' – 'magnificent seven' the seven of us who did this course together." (Q8)*

> *P15: "……I have had a wonderful experience of group therapy. I felt a great connection." (Q8)*

> *P16: "It has been a wonderful experience." (Q8)*

> *P17: "This course has really helped me. I have always avoided group work/therapy as I tend to try too hard to put on a front. This course has made me feel more confident and positive about future group work." (Q8)*

> *P21: "I want to say how grateful I am. You are all very wonderful people and this group has really helped me. Thank you so much."(Q8)*
>
> *P28: "What a life saver – this course has really helped me put things back into perspective. Thank you."(Q8)*
>
> *P29: "Thank you all so much, this course is wonderful and I hope many others benefit from it in the future."(Q8)*

P10, P11, P15, P19, P20, P21, P22 felt better about themselves:

> *P10: "...to see I am not such a bad person and help me find my way through the darker times."(Q4)*
>
> *P11: "...I am a good mum despite what he says."(Q2)*
>
> *P15: "...be gentle with myself."(Q4)*
>
> *P19: "Thank you so so so so much, this past week I have felt so in control and happy like the old me is back. I have been laughing and smiling so much more and noticing and enjoying things a lot more."(Q8)*
>
> *P20: "...smile more. Getting dressed – I don't dress in pyjamas all the time."(Q4)*
>
> *P20: "I really enjoyed myself. I don't feel alone; I look at people in the street and think they could be the same as me, not hate anymore."(Q8)*
>
> *P21: "...become the person I was before/smile a lot more/be calmer and I'm happy 70% of the time."(Q4)*
>
> *P22: "...cope and challenge my thoughts. Also encouraged me to be kind to myself."(Q4)*

In addition to feeling less isolated and happier in themselves, the participants also embraced the compassionate-focussed CBT techniques used in the course and expressed the wish to use them in their everyday lives. Their responses are detailed below under 'learning'.

Learning

The individual learning which has developed from attending the compassionate-focused CBT group has been interwoven in the participants' responses to many of the answers to the questions. Learning components include the ability to understand oneself better and others; to practise the CBT techniques learnt on the course in daily life and to be able to deal with stressful situations. However the responses to questions 5 and 6 (see below), in particular, offer learning points for the facilitators in any future group work. The learning will therefore be divided into:

a) self-learning and discovery
b) learning to benefit the running of future like-minded groups.

These quotes are taken from responses to the following questions:

Question 2 (Q2): The best things about coming were..
Question 4 (Q4): Coming to the course has helped me to..
Question 5 (Q5): I would have liked to have done more about ..
Question 6 (Q6): For the next course it would be better if ..
Question 7 (Q7): Now that the course is finishing I will ...

a) Self-learning and discovery

P2, P3, P19 felt they were able to understand themselves or others better:

> *P2: "...be more open and try different things, and to try to make more friends and be understanding in others."(Q4)*
>
> *P3: "...see that it isn't my 'problems' my friends and family don't understand, it is how much you bang on about it when you are depressed, bringing them down with you. I recognized how I had been getting a 'pay-off' by being miserable, effectively keeping me stuck. By being able to observe others in my situation, I could see what I wanted to change in myself."(Q4)*
>
> *P19: "...being aware of how my thoughts can leave me feeling and how this can affect others around me and my child."(Q4)*

P6, P8, P9, P10, P19, P20, P28 expressed the wish to use the CBT techniques in everyday life:

> *P6: "……remember the advice I have been given and put it into practise."(Q7)*
>
> *P8: "……try to carry out all the tasks that have been mentioned to cope with stress and depression."(Q7)*
>
> *P9: "…hopefully be friends with these lovely ladies. Remember to use some of the tools that I learnt about when I most need them."(Q7)*
>
> *P10: "…continue with my 'feel good book' and fill it with good things I have done each day."(Q7)*
>
> *P19: "……giving me the tools to be able to control my thoughts and feelings better and being aware when to be assertive. The book (positive) and folders were a really nice personal touch."(Q2)*
>
> *P20: "…carry on doing thinking patterns and being calm with my family; sleeping earlier."(Q7)*
>
> *P28: "…learning techniques to help me deal with difficult situations."(Q2)*

P11, P16, P17, P18, P29, P30 wanted to remain positive, calm and to be kind to themselves:

> *P11: "…try to look on the positive side of things and try to make myself happy."(Q7)*
>
> *P16: "……relax, be more calm and to think before I acted."(Q4)*
>
> *P17: "… trying to do one positive activity for myself each week…"(Q2)*
>
> *P18: "……deal with my thoughts more constructively. Also made me feel happy about myself and not putting myself down all the time."(Q4)*
>
> *P18: "It has helped me grow as a person" (Q7)*
>
> *P29: "……remember to stay positive and love myself more."(Q7)*
>
> *P30: "……be more positive and not so hard on myself and remember to do things for myself."(Q7)*

b) Learning which will benefit the running of future groups

The following responses regarding course improvement were offered by the participants. The responses involved: revisiting the notes which were used for the previous session in order to help the retention of information; sending out handouts following a group session to those participants who have been unable to attend; increasing the length of the course; plus a request for more assertiveness training and role-play.

> *P2: "……talked about notes made during the week to help us remember what we did as it's hard to remember alone and to read aloud our notes."(Q6)*
>
> *P3: "……attending. Also I would have liked the handout sheets and tasks sent to me so I could feel involved and benefit from the tasks even though I couldn't attend."(Q5)*
>
> *P10: "…It took me about two weeks to settle in and get used to sharing with others, it may therefore help if the course was longer."(Q6)*
>
> *P17: "…learning how to be assertive and honest in situations rather than passive/aggressive, as it will take a lot of practice to achieve."(Q6)*
>
> *P20: "…More scenarios (role play) to think better."(Q5)*

Summary

It is hoped that these results may allow the reader a privileged and deep insight into the fears, struggles, courage and aspirations of depressed women in addition to highlighting the benefits experienced by those participants attending the Stepping Stones Support group based on compassionate-focussed CBT. These recognized benefits serve to support the words of Gilbert (2006) who has bought compassion to the forefront of CBT work and, in so doing, has transformed the lives of many with simple acts of kindness and genuine caring. The quote below serves as the cornerstone of all work carried out within the SSS groups.

> *'Compassion is communicated in the attitude the leaders bring to each encounter, and in the manner in which they use the inherent potential of the group to connect with each other's struggles and develop a confidence in their ability to use their own experience of suffering to extend care to another. This leadership function is critical to building a climate of trust and in turn a sense of cohesiveness within the group. Attention to practical and emotional issues acts in parallel to establish trust.'*
>
> P. Gilbert, 2006 (p.373)

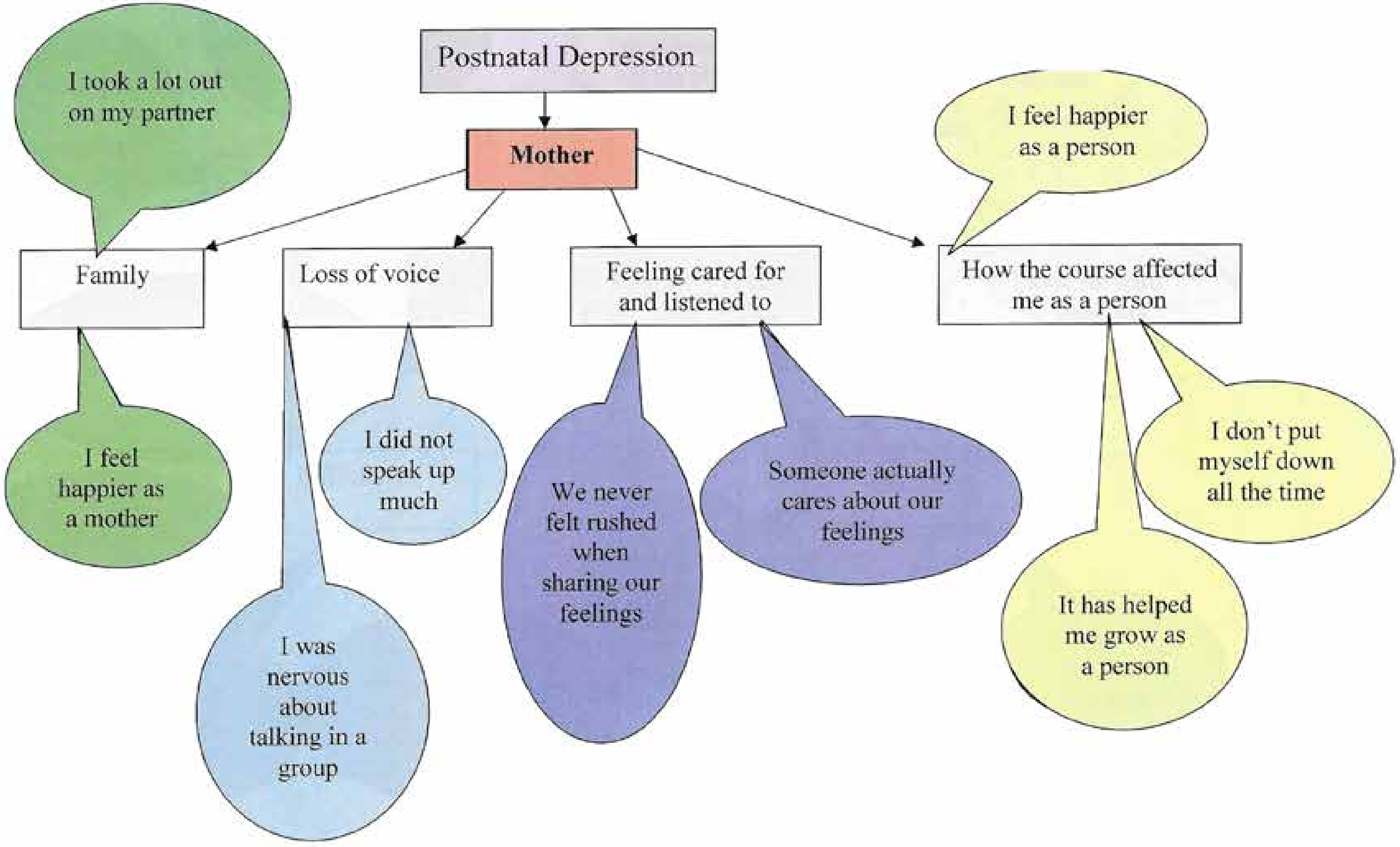
Table 1 Summary of Topics, Themes and Responses

Topics	Themes (Feelings and Thought areas)	No. of Supporting Responses obtained from the 30 collected questionnaires of the SSS group	
Low self-esteem			
	Feelings of loneliness, depression and tearfulness	15	(50%)
	Fear of speaking out	11	(36.6%)
	Feelings of anxiety, worry and self-failure	4	(13%)
Positive Feelings			
	Gratitude expressed for the group experience	20	(66.6%)
	The thought of not being along with one's feelings	17	(56.6%)
	Feeling happy about oneself and being kind to oneself	15	(50%)
	Feeling cared for	13	(43.3%)
	Being able to be more open and not hide one's feelings	9	(30%)
	Possessing the ability to look at life positively	9	(30%)
	Maintaining contact with friends made in the group	8	(26.6%)
Learning			
	Understanding oneself better and others	15	(50%)
	Practising what has been learnt	14	(46.6%)
	Being able to deal with stressful situations	14	(46.6%)

(Note: *The percentages were worked out by dividing the number of responses made in relation to a particular theme by 3 and multiplying by 10 due to the number of anonymous questionnaires collected being 30 in total. This calculation offers the reader information regarding the frequency which the themes occurred in the questionnaires)

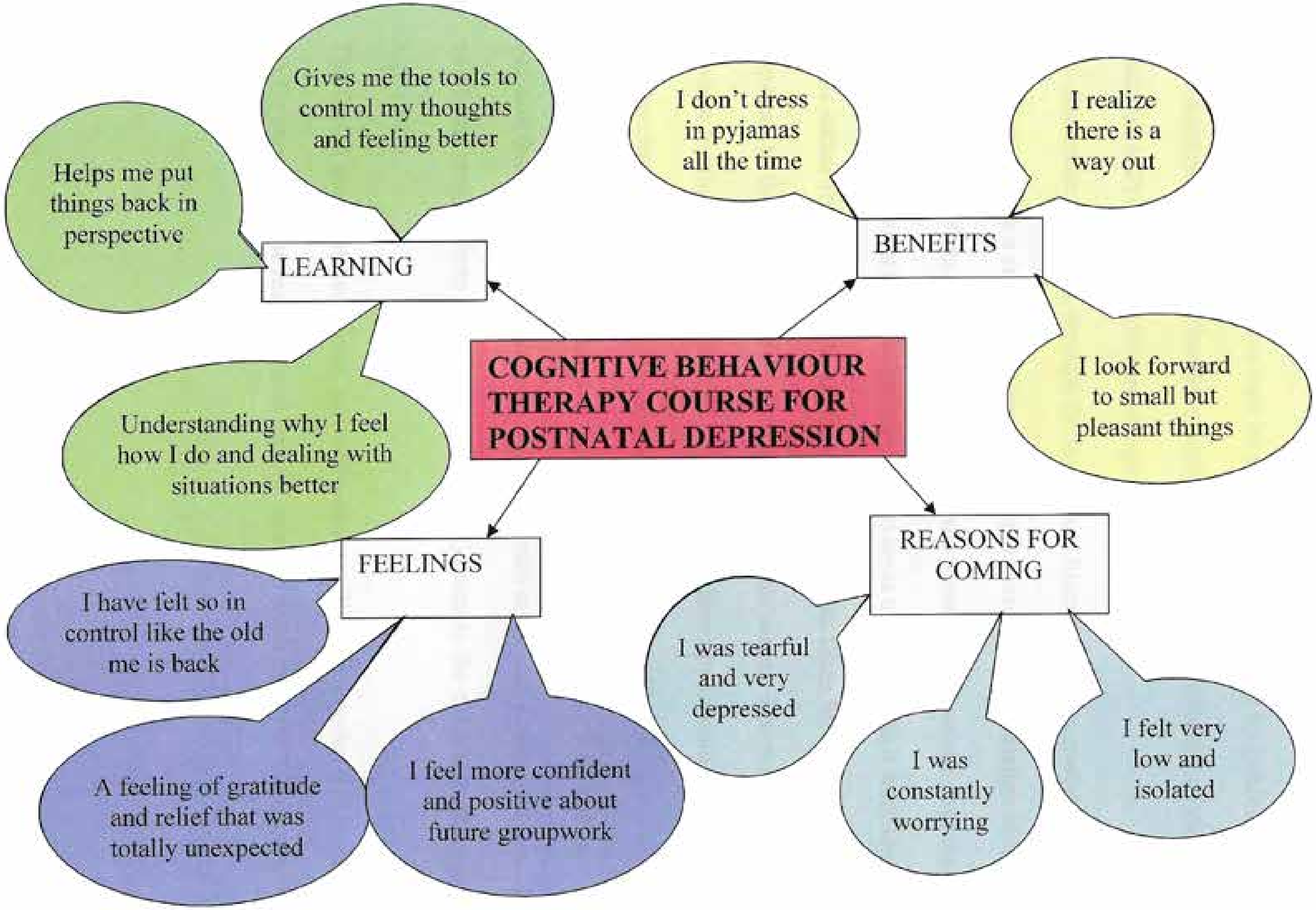
MAP A

MAPPING THE THEMES



MAP B

PRE (REASONS FOR COMING) AND POST GROUP REFLECTIONS



COGNITIVE BEHAVIOUR THERAPY COURSE FOR POSTNATAL DEPRESSION

LEARNING

- Helps me put things back in perspective
- Gives me the tools to control my thoughts and feeling better
- Understanding why I feel how I do and dealing with situations better

BENEFITS

- I don't dress in pyjamas all the time
- I realize there is a way out
- I look forward to small but pleasant things

FEELINGS

- I have felt so in control like the old me is back
- A feeling of gratitude and relief that was totally unexpected
- I feel more confident and positive about future groupwork

REASONS FOR COMING

- I was tearful and very depressed
- I was constantly worrying
- I felt very low and isolated

Discussion

This section will provide a critical analysis of the results by placing the findings in context with the theoretical backdrop of the literature review. In this way the results of this retrospective evaluation may be supported or challenged by published works or other sources of evidence, thereby offering the reader the opportunity of viewing the treatment of PND from multifaceted angles.

The discussion will work through the results and literature review methodically in an attempt to provide a comprehensive and in-depth presentation in relation to the benefits, if any, of the CFCBT group for the management of postnatal depression. It will therefore discuss the three broader subject areas or topics which were identified by the author following the streamlining of the raw data taken from the participants' responses to the questionnaires. The topic areas were namely low self-esteem, positive feelings and learning (table 1, p. 52) and, where appropriate, extracts from the participants' feedback in the questionnaires have been selected..

As in the results section, participant 1-30 will be classed as P1 or P30 and the question that the response relates to will be inserted at the end within brackets. The questions, ranging from question 1 to 8 (Q1-Q8) relate to the evaluation form in appendix 3.

The first of the identified topics, low self-esteem, will bring together a discussion on the findings from the results linked up with relevant sections of the literature review.

Low self-esteem

The feedback from the completed questionnaires (see table 1, p. 52) confirmed that 50% of the participants were experiencing feelings of loneliness, depression and tearfulness and 36.6% expressed a fear of speaking out:

> *P21: "...I felt really low, constantly worrying, crying, feeling like a failure."(Q1)*
>
> *P2: "I wanted to meet other mothers who felt the same and would not judge me on my views or things I had gone through."(Q2)*

Kendall-Tackett (2005) describes the emotions expressed by P21 above as feelings of inadequacy, excessive emotional sensitivity and pessimistic thinking while Beck (2002) believes that the loss of voice or fear of speaking out expressed by P2 above is caused by the mother's fear of the reactions of others if she admitted that she had been struggling.

This struggle with loss of voice and depersonalization is acknowledged by May (2007) a clinical psychologist, Fisher (2002) a psychiatrist cited by Barker (2009) and a patient, when he grieved the 'lamentable near disappearance of my voice' (Styron, 2004). An effective treatment for the negative ways of thinking mentioned above is recognized by NICE (2009) to be CBT due to the fact that CBT helps the person towards changing their way of thinking (cognition) and their actions (behaviour) (Beck, J. 2005).

For the purpose of this study which is to evaluate the perceived benefits to postnatally depressed women attending the SSS group based on CFCBT, it would be helpful to move on to the next topic identified by the author from the analysis of the questionnaires (table 1, p. 52) being 'positive feelings'.

Positive Feelings

The Department of Health (2010) refers to the importance of feeling cared for and considers compassion as one of the vital elements in positive patient care. This statement is supported by Helm (2009) a patient, and Thomas et al (2002) who support the need for human kindness and genuine listening in bringing about patient recovery.

Compassion, which Gilbert (2006) describes as 'an element of loving-kindness', is viewed by Eastern traditions as central to freeing the mind from the power of destructive emotions such as fear, anger, envy and vengeance (Coleman, 2003 cited by Gilbert, 2006). It is therefore interesting to note the affect of the compassionate-focussed CBT group on those participants attending the SSS groups. The following quotes have been extracted from the participants' responses to the questionnaires and cover varying aspects of kindness which appeared as a frequent theme under the topic of 'positive feelings' (table 1, p52).

(a) 'kindness to self':

P15: "...be gentle with myself."(Q4)

P2: "... be kind to myself."(Q4)

(b) 'kindness from others':

P2: "...it's nice when someone actually cares about our feelings, makes us feel worthy."(Q8)

P26: "...the openness and warmness of the group."(Q2)

(c) 'kindness to others':

P29: "This course is wonderful. I hope many others benefit from it in the future." (Q8)

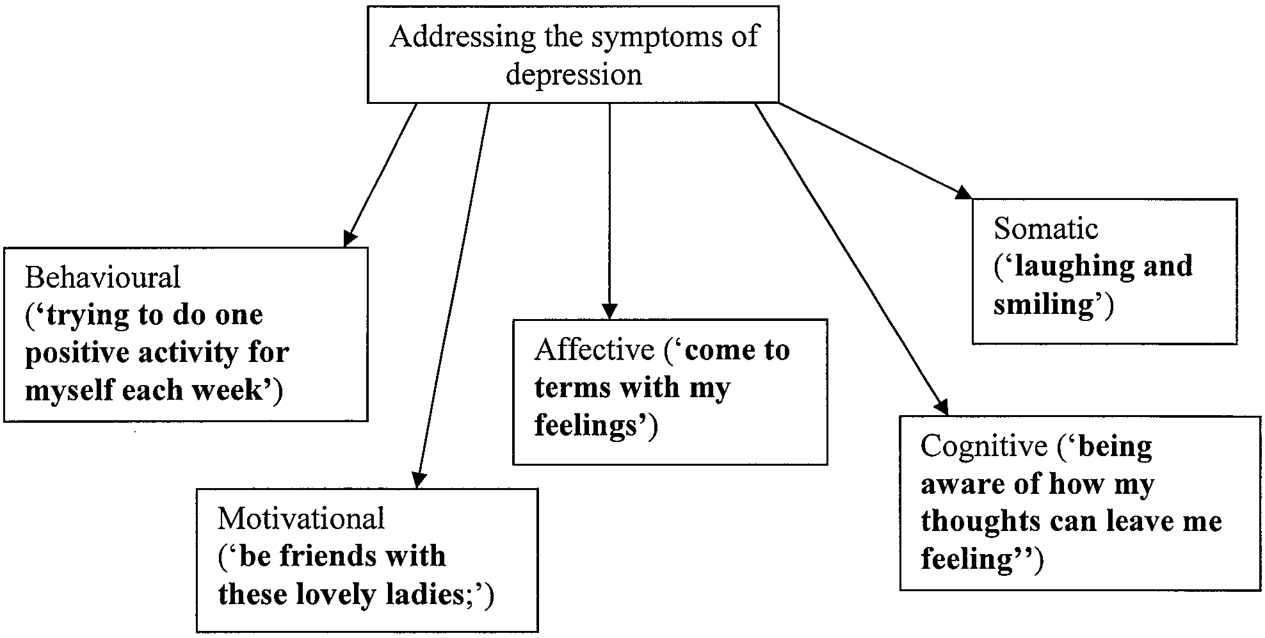
These quotes mirror Gilbert's (2006) writings on compassion where he describes the power of being cared for and listened to and also reflect part of Gilberts compassionate circle (Diagram 2, p.65) through the expression of care for well-being and empathy. However this presents as one of the drawbacks of this retrospective evaluation due to the fact that the evaluation is unable to clarify responses with the participants in a follow-up interview such as "what helped you become gentler with yourself?" or "why do you consider the course to be helpful to you?" However the feedback does provide clear evidence of benefits to the participants where movement from a critical state of mind to a more positive state may be detected within the person (e.g. 'be gentle with myself'; 'someone actually cares about our feelings'). This movement towards a more positive state of mind will be able to address depressive thoughts such as 'I'm useless' and 'No-one cares about me' (Westbrook et al, 2007). In relation to long-standing habits that are responsible for causing distress Gilbert (2006) states that, as compassion helps to encourage a kindness towards the self, this pattern of negative thinking or acting will begin to change.

In addition to the theme of kindness, participants expressed a 'coming to terms with their feelings', the ability to have fun and to enjoy friendships which are reflected in the quotes below:

1. *P1: "...come to terms with my feelings and not hiding them anymore."(Q4)*
2. *P19: "...I have been laughing and smiling so much more and noticing and enjoying things a lot more."(Q8)*
3. *P9: "...be friends with these lovely ladies."(Q7)*

Gilbert (2006) describes how the warmth and acceptance that are extended to another in compassion counter feelings of isolation, bringing the sufferer back into a relationship with another. The above quotes describe how the participants have overcome their fears of speaking out and are now able to be with others and to enjoy life without the fear of others judging them.

The development of positive feelings by the participants may also be portrayed through a personalized version of the Cognitive Model of Depression (adapted from Beck, 1967, 1976 and cited by Hawton et al, 2006). The original model appears in appendix 1. In the personalized version below extracts from participants attending the SSS groups have been placed in the relevant sections in order to demonstrate that the five symptoms of depression have been addressed.



(adapted from Beck, 1967, 1976 cited by Hawton et al, 2006)

The expression of positive feelings by the participants towards themselves and others also embraces learning elements which are covered under the next topic heading of learning (see table 1, p.52).

Learning

The learning points include 'understanding oneself better and others' and, in order to crystallize meaning, quotes have been taken from the evaluation forms completed by participants following their attendance at one of the five SSS groups.

> *P2: "...be understanding in others."(Q4)*
>
> *P10: "...I am not such a bad person ...(Q4)*
>
> *P11: "...I am a good Mum ...(Q2)*
>
> *P18: "...made me feel happy about myself."(Q4)*
>
> *P20: "...I look at people in the street and think they could be the same as me, not hate anymore."(Q8)*

This deepened understanding and acceptance of self addresses the negative self-concept and self-punitive wishes which have been recognized by Beck et Alford (2009) as components of depression. The learning however is taken a step further in the practice of what has been learnt from the compassionate-focussed CBT groups. In this way the participants will be able to transfer the skills learnt within the sessions into everyday life in order to help in the management of future stressful situations:

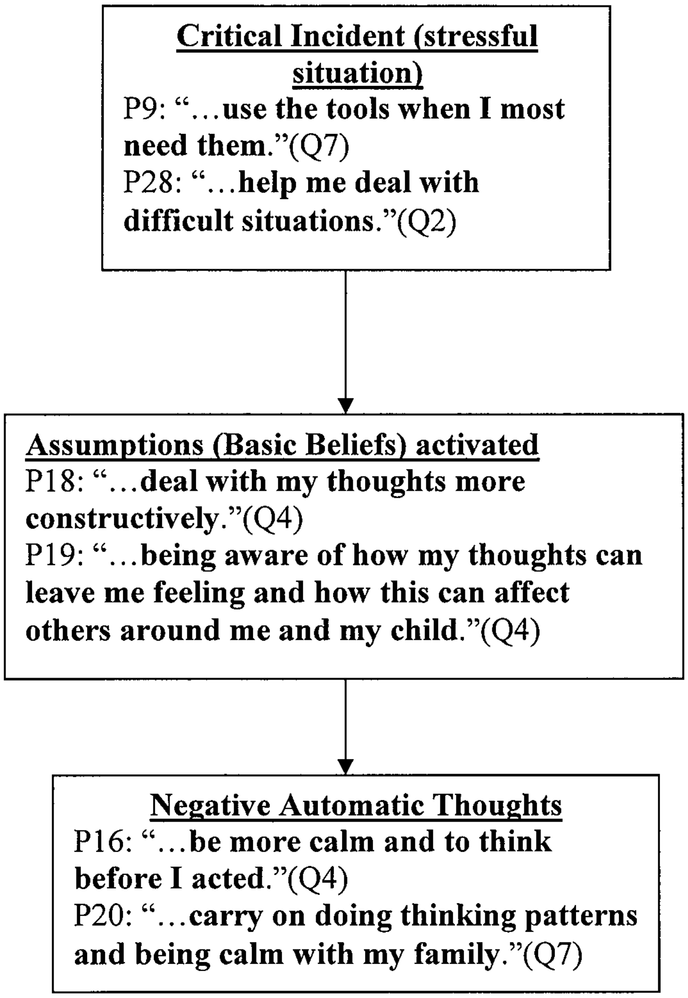
> *P9: "...remember to use some of the tools that I learnt about when I most need them."(Q7)*
>
> *P10: "...help me find my way through the darker times."(Q4)*
>
> *P28: "...learning techniques to help me deal with difficult situations."(Q2)*
>
> *P17: "...trying to do one positive activity for myself each week ..." (Q4)*
>
> *P18: "...deal with my thoughts more constructively."(Q4)*
>
> *P19: "...being aware of how my thoughts can leave me feeling and how this can affect others around me and my child."(Q7)*
>
> *P20: "...carry on doing thinking patterns and being calm with my family ..."(Q7)*

These expressions of awareness and empowerment serve as evidence to confirm the benefits of the CFCBT group to the participants attending not only in an immediate way but in a way that looks to the future and offers techniques to deal with life stressors as they arise. In relation to CBT group work Westbrook et al (2007) explain that the CBT structure of agenda setting; monitoring of affect, thoughts and behaviour; re-evaluation of dysfunctional beliefs; homework tasks and behavioural experiments can still be maintained. Westbrook et al (2007) also state that, apart from economic considerations, other advantages of group work include the economy of the therapist's time, the normalisation of group member's experiences and the fact that clients can often spot in others what was not obvious in themselves. The latter two points are conveyed in the quotes below:

> *P11: "...realizing that I'm not the only one who has problems."(Q2)*
>
> *P3: "...by being able to observe others in my situation I could see what I wanted to change in myself."(Q4)*

Mazure et al (2006) clarify that the onset of PND may not only be caused by hormonal changes (Taylor et al, 2007) but may also be compounded by life stressors. The CFCBT group therefore offers a broad approach in learning how to deal with postnatal depression by addressing not only the mother's inner feelings but also providing a lifeline to deal with outside stressors. The benefits from this approach may be appreciated by referring once more to the Cognitive Model of Depression adapted from Beck, 1967, 1976 and cited by Hawton et al, 2006 (appendix 1) which has been adapted in the following model.

The CFCBT group responses to the management of stressful events



Critical Incident (stressful situation)
P9: "...**use the tools when I most need them**."(Q7)
P28: "...**help me deal with difficult situations**."(Q2)

Assumptions (Basic Beliefs) activated
P18: "...**deal with my thoughts more constructively**."(Q4)
P19: "...**being aware of how my thoughts can leave me feeling and how this can affect others around me and my child**."(Q4)

Negative Automatic Thoughts
P16: "...**be more calm and to think before I acted**."(Q4)
P20: "...**carry on doing thinking patterns and being calm with my family**."(Q7)

(adapted from Beck 1967, 1976 and cited by Hawton et al, 2006)

In the aforementioned model, the participant of the CFCBT group deals with the critical incident or stressful situation by using learnt techniques. This in turn helps to address any negative basic beliefs from which develop negative automatic thoughts (Beck et al, 2009). This process assists the participant to maintain both perspective and awareness and, ultimately, to become more in touch with both themselves and the outside world. In addition to the use of standard CBT techniques, the compassionate-focus using the criteria illustrated in diagram 2 (p. 65) of the compassionate circle (Gilbert, 2009a) serves to soften the individuals reaction to their own troubled experience (Gilbert, 2007).

The CFCBT groups bore similarities with the CBT group by Gordon (Gordon et Tobin, 2010) which worked by promoting awareness in the women of their real feelings. This newly found awareness has been reflected in:

> *P19: "…I have felt so in control and happy…"(Q8)*
>
> *P21: "…become the person I was before …"(Q4)*
>
> *P28: "…put things back into perspective."(Q8)*

This restored confidence and happiness would address Bowlby's (1951) concern regarding the negative effect of PND on the emotional development of the child in addition to its effect on the partner (Bancroft et al, 2008).

Summary

Attendance at the CFCBT groups was facilitated by the provision of transport in the form of taxis to and from the participant's home in addition to crèche facilities for the children in an effort to relieve some of the stress that surrounds the attendance of such a group. The provision of a crèche and a comfortable room helped to provide a 'safe and secure environment' which is mentioned below by one of the participants.

> *P28: "The best things about coming were a safe and secure environment to speak about how I'm feeling."(Q2)*

Dennis et al (2009) recognize that a lack of these facilities presents as a significant barrier to receiving treatment for postpartum depression.

Telephone contact was also made in the form of text messaging, calls to mobile or land lines, as agreed with the participant, before and after each group session in order to offer the personal and compassionate touch that is present in caring and offering empathy and sympathy where needed (Gilbert, 2009b). It is in these small acts of kindness where compassion may be conveyed. Other small acts of loving-kindness (Gilbert, 2006) involved a personalized folder with the participant's first name on at the beginning of the course for their handouts, an abundance of refreshments in the form of tea and coffee, fruit or cake available plus a personal gift to each participant at the end. Perhaps it is all these little things that are in fact the big things and have led 66.6% of the participants to express their gratitude for the group experience.

> P29: *"Thank you all so much, this course is wonderful and I hope many others benefit from it in the future."*

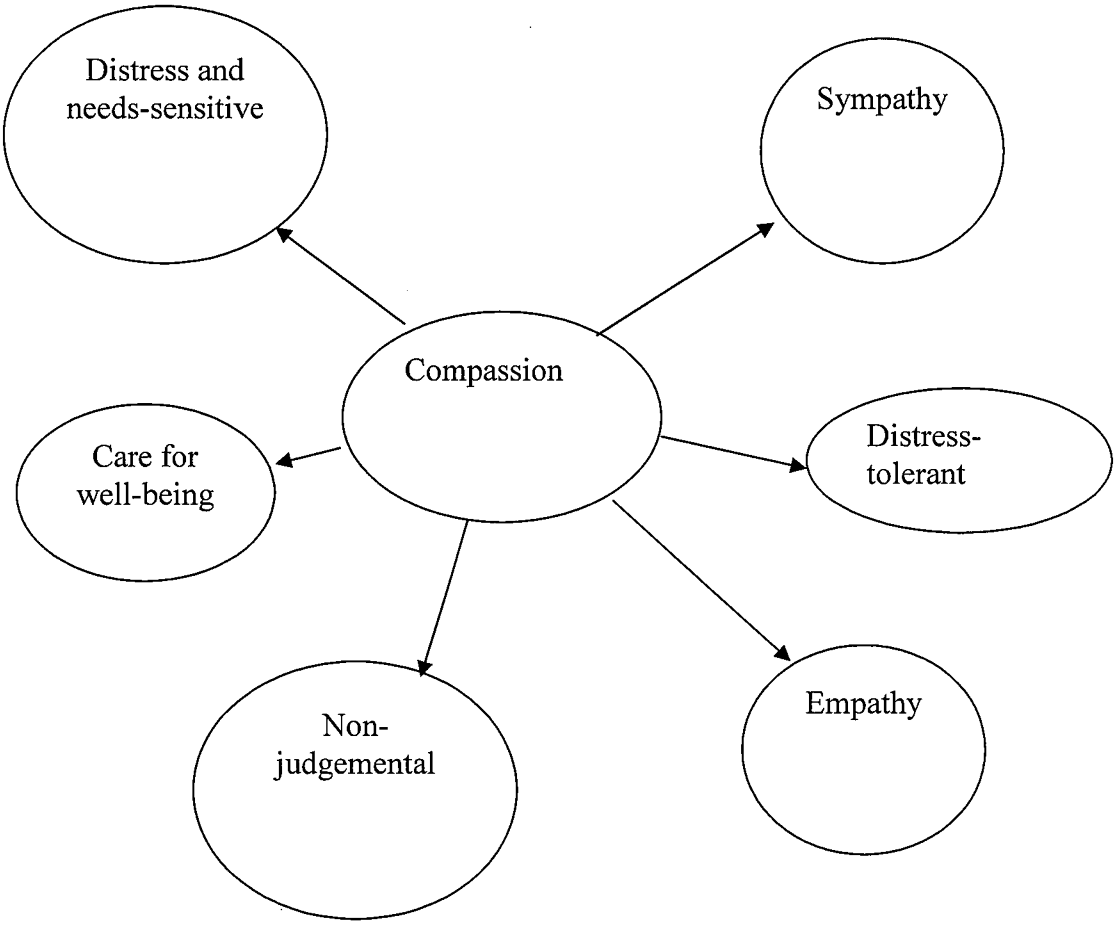
Up to the present time NICE (2009) has only acknowledged CBT as an effective treatment in the management of depression but does not include PND. NICE (2009) also does not mention the use of CFCBT. However this evaluative study has achieved a broad spectrum of benefits in relation to the management of PND using CFCBT techniques. This is explained more fully in the following comparison. On the left hand side are depressive thoughts extracted from the writings of Westbrook et al (2007) and, on the right hand side are extracts of quotes taken from the feedback received from the participants of the groups which relate specifically to the depressive thought in the opposite column and offer an alternative perspective or outlook.

Depressive Thought	**Feedback of participants following attendance at the SSS groups**
I'm useless, inadequate	P18: "…feel happy about myself"(Q4)
No-one cares about me	P2: "..someone actually cares about our feelings."(Q8)
It will always be like this	P11: "I realize there is a way out."(Q4)
(Westbrook et al, 2007)	(Direct quotes from participants)

The current findings of this retrospective evaluation have been both illuminating and encouraging with the power of the feedback coming directly from the heart of the participants. The use of direct quotes has been instrumental in preserving the genuine and rich meaning of the postnatally depressed mothers in order to 'let the words speak' Barker (2009).

Diagram 2

The Compassionate Circle (Gilbert, 2009b)



Conclusion

The findings in this evaluative study suggest that support groups offered to mothers suffering from PND, incorporating CFCBT techniques, can be effective in alleviating the symptoms of depression, in addition to providing the tools to cope with family life, motherhood and to address future life stressors. However the retrospective evaluation also identified that, the compassionate focus integrated within the CBT group work, enabled the mothers to develop self-kindness and to experience the feeling of being cared for.

In view of the long-term aim to encourage the setting up of groups elsewhere in the United Kingdom, it appears that the criteria of the SSS group in Diagram 1 (p.22) meet the demands of recent government reports. The relevancy of the group to such reports is clarified below.

The SSS group offers early targeted support for emotional and mental health problems (DH, 1999a, 2004, 2006) in the postnatal period (DH, 2002a, 2004), at the same time supporting mothers and enabling children to have a good start in life (Cabinet Office, 2006; DH, 2001; Department for Education and Skills, 2003). The SSS group also brings together professionals from the voluntary and health sectors encouraging working partnerships and interagency, multi-professional collaboration (DH, 2002b; 1999b). The work of the SSS group remains client-centred (DH, 2000) and is organised and conducted by staff with knowledge and skills to design and deliver services (DH, 2002a).

Cost and Training

The compassionate-focussed cognitive behavioural therapy group (otherwise known as the Stepping Stones Support group) has demonstrated through the results and discussion arising out of the retrospective evaluation of the anonymous questionnaires, clear benefits to the postnatally depressed women who attended one of the five SSS groups evaluated for this study.

Economically the group cares for six to eight women over a six week period for two hours once a week (excluding preparation and feedback time plus telephone contact between group meetings) by two NHS workers and two charity workers, therefore expenses are minimised in relation to labour costs although the cost of the meeting room, crèche and transportation remain.

The issue of running the groups with mixed professionals (with one professional being CBT trained) appears to be well accepted by the participants with 66.6% (i.e. 20 out of 30 participants) expressing gratitude for the group experience.

Acknowledging the limitations

Unfortunately this retrospective evaluation has been limited to five groups and, owing to its anonymity, it has not been possible to carry out a follow-up contact with clients in order to identity the long-term benefits of attending such a group. It would be helpful to conduct future groups where a follow-up would be integral to the study in order that this area of knowledge could be explored. It would also be important, in view of the recognised problem of paternal depression (Bancroft et al, 2008) for support to be offered to the partner of the postnatally depressed mother. Milgrom et al (2006) offers an outline of a programme to include fathers in a couple's support group which would serve as a helpful template for partner involvement in the future.

In Map A (p.53) one of the participants recognized that "I took a lot out on my partner." As PND is recognized to have such far reaching effects on the global health of the mother, father and children plus on relationships with the wider world (Persaud, 2007), it appears imperative that this forgotten area of need is addressed.

Nevertheless, it needs to be recognized that this evaluative study has only involved postnatally depressed women and, in the light of evidence to suggest that many stressors and predisposing risk factors are present in both the antenatal and postnatal period (Buist, Ellwood, Brooks, Milgrom, Hayes, Sved-Williams, Barnett, 2007; Robertson, Grace, Wallington, Stewart, 2004), it would appear wise to broaden support in the future to include the antenatal period, adopting a compassionate-focussed approach in an individual or a group setting. In the antenatal setting alternative methods of assessment would be necessary as regards the diagnosis of depression such as the use of the PHQ-9 (Kroenke, Spitzer et Williams, 2001, appendix 10).

However the short-term benefits are evident and it seems appropriate that the concluding words should be taken from a response of one of the participants of the SSS group who has been instrumental, along with each member of the five groups, in bringing this piece of work to fruition. The words reflect her ability to recognize the joy in life, to refind her 'old self' but, at the same time, to cherish her role as a mother.

> *P19: "Now the course if finishing, I will treasure the positives and highs everyday. Remembering that the 'old me' is still here but now I am a Mummy which is something I love."*

Dissemination

Dissemination of the findings of the retrospective evaluation is a vital component of this piece of work with the purpose of expanding the knowledge base of professionals involved in the treatment of women suffering from postnatal depression. These professionals would include community staff working within the Primary Health Care Trust ranging from the General Practitioner to the Midwifery, Health Visiting and Mental Health teams.

The findings may be presented at multiple venues including forums, staff meetings, working parties, patient empowerment groups and in funding applications to support future group work in this area of need.

In relation to the global perspective, it would be appropriate to offer the findings for publication in relevant journals concerned with the mental health of the antenatal and postnatal mother, her partner, her children and the wider social network.

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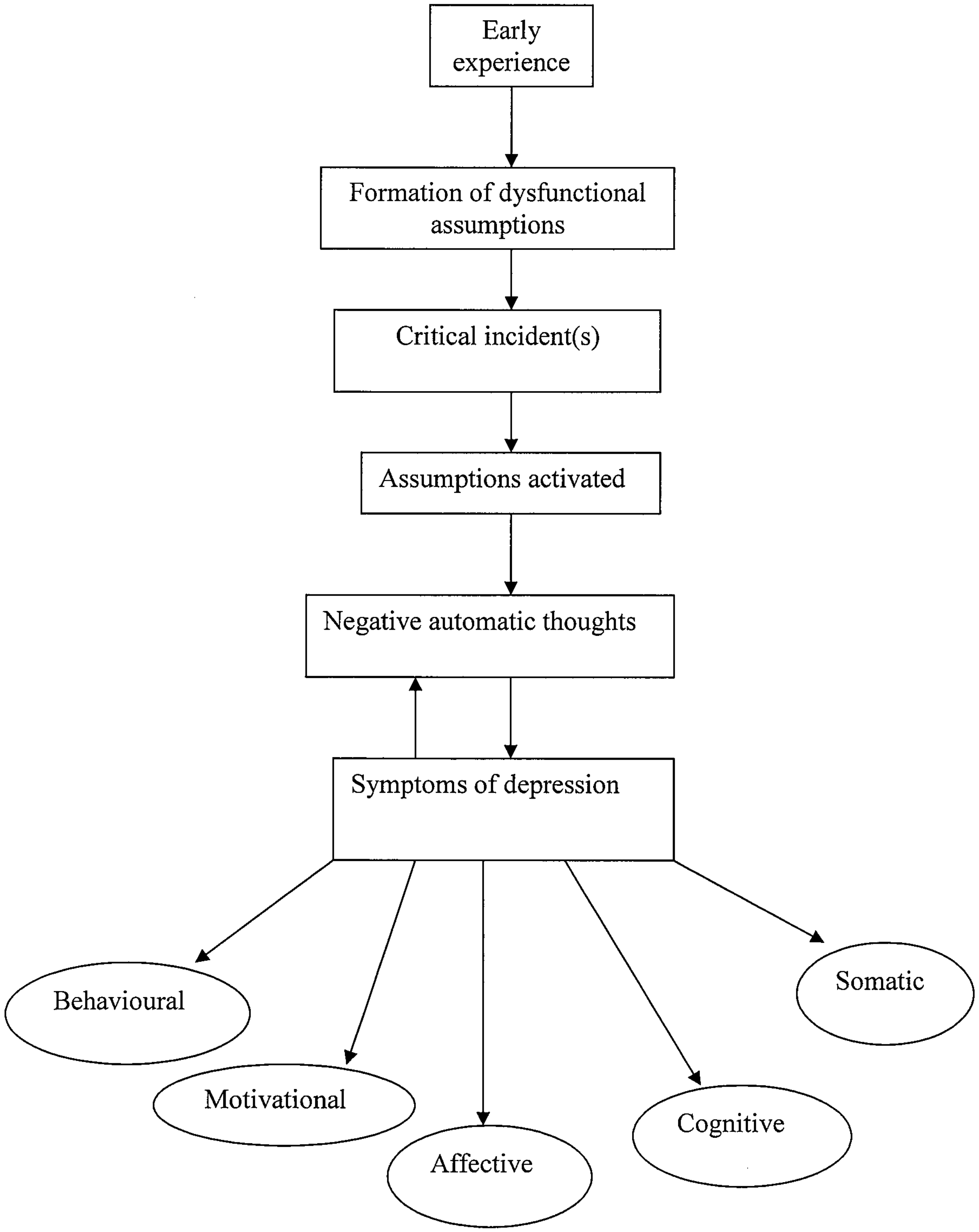
Appendix 1

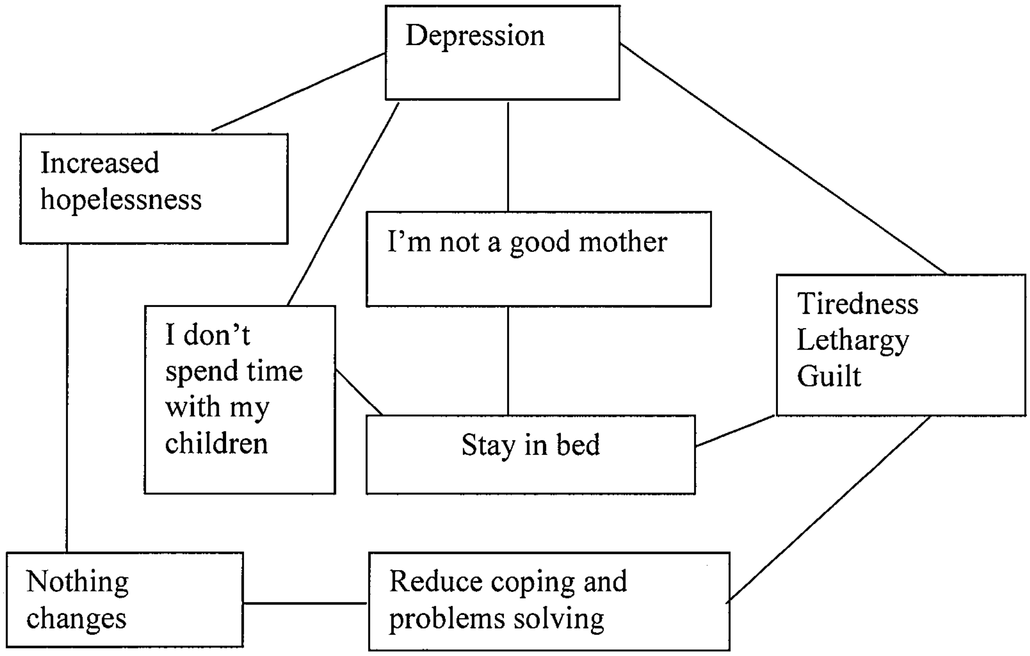
The Cognitive Model of Depression (Beck, 1967, 1976 cited by Hawton et al, 2006)

This model proposes that past experiences in people's lives are instrumental in the formation of assumptions or schemata about themselves and the world in which they live. These assumptions then progress to being used in the development of perception and subsequent behavioural patterns.



Appendix 2

Common maintenance processes in depression (Westbrook et al 2007)



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Appendix 3

STEPPING STONES SUPPORT GROUP

END OF COURSE EVALUATION FORM

Date:

1. **I came to this Support Group because …**

2. **The best things about coming were …**

3. **The worst things were …**

4. **Coming to the course has helped me to …**

5. **I would have liked to have done more about …**

6. **For the next course it would be better if …**

7. **Now the course is finishing I will …**

8. **Is there anything else you would like to say? …**

Appendix 4

PARENT SUPPORT GROUP
PRE GROUP/POST GROUP

The Edinburgh Postnatal Depression Scale (EPDS)

The EPDS is a ten-item questionnaire developed for screening for PND in the Community. It has good reliability and validity, and cut-off points of >12 have been shown to have 67.7 - 100% sensitivity and 78 - 95.7% specificity for detection of currently distressed/depressed cases in community samples (Murray et Carothers, 1989)

FEELINGS AND MOODS
IN
MOTHERHOOD

NAME............................ DATE..................

Please underline the statement for each of the following items that best describe how you have been feeling over the past seven days.

Here is an example, already completed.
I have felt happy:

Yes, all the time

Yes, most of the time

No, not very often

No, Not at all

---

1. I have been able to laugh and see the funny side of things:

   As much as I always could

   Not quite so much now

   Definitely not so much now

Not at all

2. I have looked forward with enjoyment to things:

    As much as I ever did

    Rather less than I used to

    Definitely less than I used to

    Hardly at all

3. I have blamed myself unnecessarily when things went wrong:

    Yes, Most of the time

    Yes, some of the time

    Not very often

    No, never

4. I have worried and anxious for no good reason:

    No, not at all

    Hardly ever

    Yes, sometimes

    Yes, very often

5. I have felt scared and panicky for no good reason:

    Yes, quite a lot

    Yes, sometimes

    No, not much

    No, not at all

6. Things have been getting on top of me:

    Yes, most of the time I haven't been able to cope

    Yes, sometimes I haven't been coping as well as usual

No, most of the time I have coped quite well

No, I have been coping as well as ever

7. I have been so unhappy that I have difficulty sleeping:

   Yes, most of the time

   Yes, sometimes

   Not very often

   No, not at all

8. I have felt sad and miserable:

   Yes, most of the time

   Yes, quite often

   Not very often

   No, not at all

9. I have been so unhappy that I have been crying:

   Yes, most of the time

   Yes, quite often

   Only Occasionally

   No, never

10. The thought of harming myself has occurred to me:

    Yes, quite often

    Sometimes

    Hardly ever

    Never

Thank you.

Appendix 5

The Characteristics of a Service Evaluation by the National Patient Safety Agency (2007)

The National Patient Safety Agency (NPSA) offers the following guidelines in relation to the characteristics of a Service Evaluation project:

- Designed and conducted solely to define or judge current care;

- Designed to answer the question 'What standard does this service achieve?'

- Measures current service without reference to a standard;

- Involves an intervention in use only;

- Usually involves analysis of existing data, but may include administration of simple interview or questionnaire;

- No allocation to intervention groups: the healthcare professional and patient have chosen intervention before service evaluation;

- No randomisation;

Service Evaluation does not require a Research Ethics Review.

Appendix 6

E mail copies of correspondence with the Comprehensive Local Research Network (CLRN), Research Management and Governance (RM&G) Facilitator plus the Supervisor at Anglia Ruskin University, with reference to a consultation with Dr. Andrew Stevens, Vice-Chairperson, Essex one, Integrated Research Application System (IRAS).

----- Original Message -----
From: Casey Ayse (5PV) West Essex PCT
To: Pat Alexander
Sent: Tuesday, December 01, 2009 10:50 AM
Subject: RE: Research proposal

Hi Pat,
I think it's a great that you've got advice from an ethics committee.
Best regards
Ayse

From: Pat Alexander [mailto:pattyalexander@tiscali.co.uk]
Sent: 28 November 2009 21:41
To: Casey Ayse (5PV) West Essex PCT
Cc: j.teatheredge@anglia.ac.uk; Keel Carol (5PV) West Essex PCT
Subject: Research proposal

Dear Ayse,
I hope this finds you well. I refer to your helpful comments below sent on 6th November. On 27th November I was able to meet with my supervisor, Julie Teatheredge, at Anglia Ruskin University Chelmsford and discussed your concerns. During our session Dr. Andrew Stevens, vice chair of the Essex One Iras walked past so we were able to ask his advice on the attached questionnaire. He considered that it would be acceptable as a service evaluation which will not require ethics approval due to the fact that it is anonymous, it is done in conjunction with the charity Homestart and has no West Essex Pct. logo on it and therefore cannot be related to the NHS. He said if there were any problems that he would be very happy to be contacted.
I do hope that the above is acceptable to you and thank you for the help and guidance you have offered. Please let me know if you consider there are any other steps I should be taking before undertaking the research.
I look forward to hearing from you.
with grateful thanks,
Pat

-----Original Message-----
From: Alexander Pat (5PV) West Essex PCT
Sent: 06 November 2009 16:56
To: Casey Ayse (5PV) West Essex PCT
Cc: Keel Carol (5PV) West Essex PCT
Subject: RE: Research proposal

Dear Ayse,
Thank you very much for your comments which I will take away with me and have a good think about over the weekend! I appreciate your encouragement and your positive feedback. The work actually developed from the course I am doing on CBT - I began the group with a colleague in partnership with the charity homestart and we agreed to do three pilot groups to monitor its success. I did not plan to do research or a course evaluation on it but as feedback has been so positive we are planning next year to write the protocol for it and, hopefully, to eventually roll it out across the trust. I considered a piece of research/evaluation work would further validate the effectiveness of the group work. From your comments it appears that it may well be difficult to go forward with what I am proposing to do; the reason I chose the open style questionnaire is because it is rich in content although we also did the edinburgh post natal depression score pre and post group. However this obviously is not so reflective of the client's reactions to the course. I discussed possible analysis of the open questionnaires with the librarian at PAH post graduate library using a specific computer programme and she advised me that a colleague she knew had experience in this type of analysis so that, at a future date, I planned to discuss this with her.
Thank you so much for your invitation to come back to you if I need to and for your detailed feedback. Time

to put my thinking cap on now I think, and I will follow the advice you have so kindly provided me with.
with kind regards
Pat

From: Casey Ayse (5PV) West Essex PCT
Sent: 06 November 2009 10:39
To: Keel Carol (5PV) West Essex PCT
Cc: Alexander Pat (5PV) West Essex PCT
Subject: RE: Research proposal

Hi Carol/Pat

First, this looks like a really good piece of work!

However, I think this is a tricky one. Originally I thought this would be a service evaluation, however the questions are probing a little bit deeper and finding out more regarding what the individuals are getting from the programme. I have to say that I think it veers more to research than to evaluation. It might be an idea to get some advice from the NRES people http://www.nres.npsa.nhs.uk/applications/guidance/. If it is deemed to be research then retrospective consent would be required. This will be VERY difficult to get. Happy to offer advice if you need it.

Also, as a separate comment. This kind of data would be very hard to analyse and would only provide rich enough data if you've got some experience in collecting and analysis this sort of qualitative data. (Sorry Pat I have no idea of your history and don't know whether you've had much experience in this area. Please ignore me if you have!!) It would also be interesting to know if the programme has been validated already or whether it's a new thing?

My suggestion would be change the style of the questions very slightly to make them more quantitative which would make it easier to analyse and glean result from. Again, happy to offer some advice if you need/want it.

Pat: do you need to do a piece of research or is your course flexible so that it could be service evaluation?

I hope this helps. Please feel free to give me a call if you need some more/other advice.

Best regards and best of luck!
Ayse

Ayse Casey
CLRN RM&G Facilitator
Office: 01279 410 496
Mobile: 07917596541

From: Keel Carol (5PV) West Essex PCT
Sent: 05 November 2009 15:46
To: Casey Ayse (5PV) West Essex PCT
Cc: Alexander Pat (5PV) West Essex PCT
Subject: FW: Research proposal

Dear Ayse

Hi. I am just writing to pick your brain. I wonder if you can advise Pat Alexander, one of our local Health Visitors who is currently undertaking her MSc.

I have attached Pat's very rough draught proposal. What I would like you to look at is the Questionnaire, Stepping Stones, pg 4, Appendix 1.

As part of Pat's work, she is involved in running a 6-week Cognitive Therapy Community based Programme for mothers who suffer with Post Natal Depression. Following the 6-week course, they are asked to complete the anonymised Questionnaire, pg 4. As this questionnaire provides such rich data, Pat would like to look at 3 groups questionnaires' retrospectively (each group consisted of 8 mothers, so 24 Questionnaires' in total). Now, is this Research or Service support Evaluation? Does she need Ethical approval to do this? Also, does she need retrospective informed consent forms from the women to give consent that this is going to be used for a research project as that was not the original intention for this information?

I look forward to your words of wisdom.

Kind regards
Carol

Carol Keel
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Essex & Hertfordshire
Comprehensive Local Research Network (CLRN)
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Appendix 6

E mail copies of correspondence with the Comprehensive Local Research Network (CLRN), Research Management and Governance (RM&G) Facilitator plus the Supervisor at Anglia Ruskin University, with reference to a consultation with Dr. Andrew Stevens, Vice-Chairperson, Essex one, Integrated Research Application System (IRAS).

----- Original Message -----
From: "Teatheredge, Julie" <Julie.Teatheredge@anglia.ac.uk>
To: "pat alexander" <pattyalexander@tiscali.co.uk>
Sent: Thursday, March 04, 2010 4:37 PM
Subject: RE: Initial Major Project Proposal

Hi Pat that sound fine to me, we checked with andy it was an evaluation Regards julie

-----Original Message-----
From: pat alexander [mailto:pattyalexander@tiscali.co.uk]
Sent: 02 March 2010 21:00
To: Teatheredge, Julie
Subject: Fw: Initial Major Project Proposal

Hello Julie,
I received the following comments from Rollanda. I guess, with reference to point 1, that I should just leave the first objective out? Then, with point 2, there has been no approval sought as the questionnaires were used only as a means of service evaluation and not as a part of a research project. Is this adequate clarification now please Julie? Looking forward to hearing from you. with kind regards Pat

Hi Pat

Attached is the feedback for your Initial Major Project Proposal.

Two points were raised:
1) your first objective is not appropriate for the research
2) whether you need to seek permission from the appropriate ethics committee that approved the original research to use the existing data for your study.

Please clarify the identified points with your supervisor.

Best wishes
Rollanda

Dr Rollanda Law
William Harvey Building 2nd Floor
Dept of Allied Health
Anglia Ruskin University
Tel: 0845 196 4188

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Appendix 7

What is the Stepping Stones Support group?

Dear Parent,

Our group is for those mothers who have a child or children under 5 years of age, who are struggling with low moods. Some mothers explain these feelings as 'wearing a mask' where they appear happy to the outside world but, when the mask comes off inside their home, this 'happiness' becomes sadness.

Our group gently takes you through ways to help you feel a little better and, most importantly, helps you feel as though you are not alone.

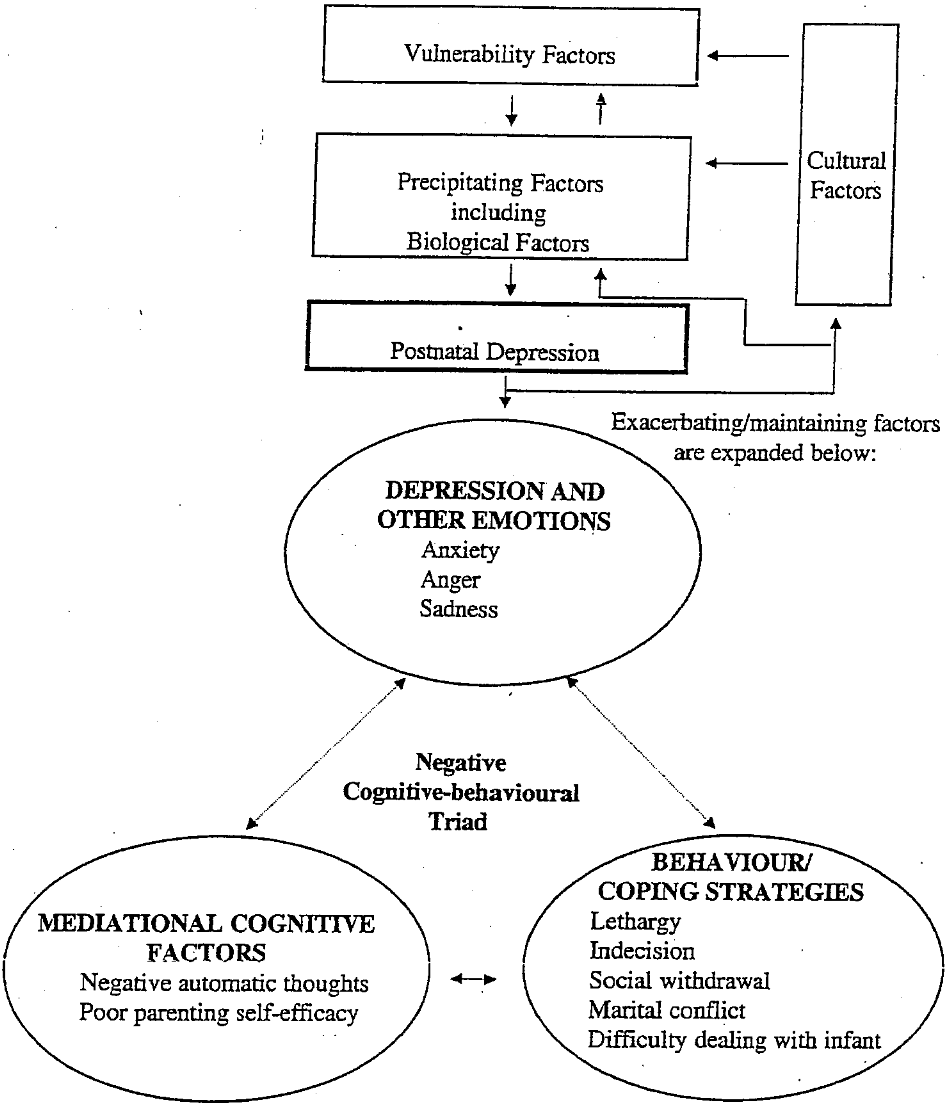
We meet for six sessions, once a week, which will be at the .... Centre (address above) and, once your health visitor has referred you or you have contacted us yourselves (ring ....), we will be in touch to come and see you at home before the group begins to explain a little more about the group and to answer any questions you may have. Our next group begins on ....

We look forward to spending time with you.

With our warm wishes

Appendix 8

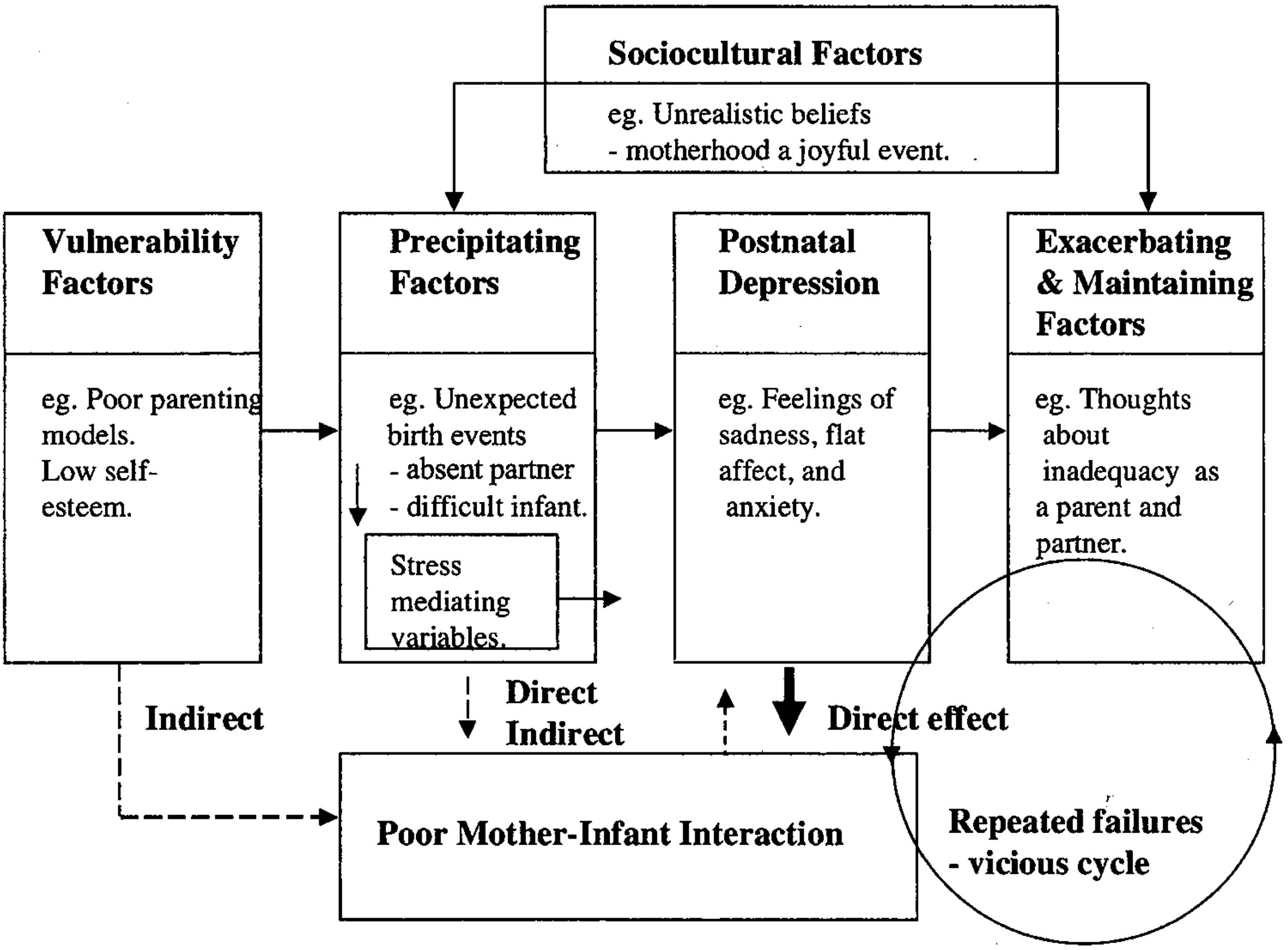
Model of postnatal depression intervening with multiple contributory factors (Milgrom, Martin et Negri, 2006)



Appendix 9

The Biopsychological Model of Postnatal Depression

(Milgrom, Martin et Negri, 2006)



Appendix 10

Patient Health Questionnaire Depression Scale (PHQ-9) Kroenke et al (2001)

The Patient Health Questionnaire (PHQ) is a brief 9-item self report questionnaire specifically developed for use in primary care and used extensively in the United States. The PHQ-9 has acceptable reliability, validity, sensitivity and specificity as an assessment tool for the diagnosis of depression in primary care. The questionnaire can also be used to monitor progress with possible scores ranging from 0 to 27 with higher scores indicative of increasing severity.

PATIENT NAME DATE

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

A. Little interest or pleasure in doing things

Not at all **Several days** **More than half the days** **Nearly every day**

B. Feeling down, depressed, or hopeless

Not at all **Several days** **More than half the days** **Nearly every day**

C. Trouble falling asleep, staying asleep, or sleeping too much

Not at all **Several days** **More than half the days** **Nearly every day**

D. Feeling tired or having little energy

Not at all **Several days** **More than half the days** **Nearly every day**

E. Poor appetite or overeating

Not at all **Several days** **More than half the days** **Nearly every day**

F. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down

Not at all **Several days** **More than half the days** **Nearly every day**

G. Trouble concentrating on things such as reading the newspaper or watching television

Not at all **Several days** **More than half the days** **Nearly every day**

H. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual

Not at all **Several days** **More than half the days** **Nearly every day**

I. Thinking that you would be better off dead or that you want to hurt yourself in some way

Not at all **Several days** **More than half the days** **Nearly every day**

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult at All **Somewhat Difficult** **Very Difficult** **Extremely Difficult**

coring the PHQ-9 when used to measure severity:
f the 9 items in question 1, count one point for each item ticked 'several days', two points for each ticked 'half the days' and three oints for those ticked 'nearly every day'. Sum the total for a severity score.

PHQ-9 continued

Recommended categories for Response and Monitoring with the PHQ-9

Score	Severity
Less than 10	Mild depression
10 – 14	Moderate depression
15 – 19	Moderate to severe depression
Greater than 20	Severe depression

Definition of improvement

Improved: A reduction of 2 or more points on the baseline score

Not improved: Drop of 1 point or no change or increased score

A RETROSPECTIVE EVALUATION ON THE PERCEIVED BENEFITS TO POSTNATALLY DEPRESSED WOMEN ATTENDING A SUPPORT GROUP BASED ON COMPASSIONATE-FOCUSSED COGNITIVE BEHAVIOURAL THERAPY

BY

PATRICIA I. ALEXANDER