
Elpitha
A Group of Hope

WHY THE SNOWDROP?

The snowdrop is a delicate symbol of hope and optimism. It reflects perseverance and strength in adversity as it is the first flower of spring being able to melt the snow with its own heat.

The snowdrop is a flower of natural beauty that reflects the unique gift that each individual has to offer the world.

It is a sign of transformation (where the winter transforms into spring) and it is hoped, be it in a small way, that the sadness of the mothers who attend be slowly transformed into a happier state of being.

THE PHILOSOPHY FOR ELPITHA SUPPORT GROUP

It is our dream to make the Elpitha group available to all mothers across the globe under the umbrella of Home-Start.

We believe in open hearts, in giving generously and in no profit-making activities.

We will work tirelessly to maintain the simplicity, the humility and the compassion upon which the group is based.

We shall also strive to train those dedicated volunteers in the field to become facilitators in order that the group remains in the safekeeping of charitable organisations.

ELPITHA SUPPORT GROUP

The following writings provide the complete package for running the Elpitha Support Group

IN SUMMARY THESE ARE AS FOLLOWS:

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ELPITHA SUPPORT GROUP

FACILITATOR'S TRAINING MATERIAL

ELPITHA SUPPORT GROUP
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WELCOME TO THE TRAINING FOR THE FUTURE FACILITATORS

During the training days that we are spending together we will cover the Elpitha six week course in a living vibrant way with yourselves being the clients and ourselves as the facilitators.

We will weave in the theory of compassionate Cognitive Behavioural Therapy (CBT) within each session and explore together the challenges that running such a group presents.

It will be an intense time which we hope will reflect, to some degree, the journey that we experience with those mothers with whom we have been fortunate to work over in the previous few years.

As future facilitators the main requirement is a compassionate heart that is non-judgemental and non-critical. We also need to have the courage to be able to share, to a small degree, our own vulnerabilities in order to promote trust and a feeling of equality. Occasionally group members may challenge us and this is dealt with by thanking them for their comments and remaining open to learning; sometimes an apology may even be appropriate. Finally a sense of humour is essential and always saves the day!

Welcome to a voyage of discovery that shall take you to the depth of human suffering but shall also offer the immense privilege of being with courageous, beautiful people who will slowly be able to find themselves again with your help and support. Each group is quite unique and full of unexpected surprises and amazing moments of discovery.

OUR AIMS AND OBJECTIVES

AIM

To offer a training package to prospective facilitators for the Elpitha support group

OBJECTIVES

Elpitha Facilitators

1. Through the training of grassroot workers, to increase the accessibility to groups for depressed mothers of children under five years of age (Kennedy et Pearson, 2015, train volunteers with no mental health background to address psychological problems with disadvantaged young people in India)
2. To empower volunteers with the knowledge of Compassionate Cognitive Behavioural Therapy (CCBT) thereby decreasing costs and waiting lists to receive this treatment. (Husain et al, 2014, obtained encouraging results which revealed, by including non-medical clinicians in the treatment of depression, that relatively low cost interventions can have a significant effect on the severity of depression and quality of life).

Group Members

3. To relieve the isolation experienced by depressed mothers through providing an atmosphere of warmth and acceptance during attendance at the group sessions (Hubbard, 2009; Gilbert, 2006)
4. To offer on-going support through Home-Start's weekly family group sessions following completion of the six course in addition to one or several reunions post group
5. To raise self-esteem and feelings of self-worth for the mothers attending through the delivery of a structured programme using CCBT strategies, that also offers flexibility in its approach to care
6. To provide crèche facilities for the children of attendees in order to enable children to develop their social and developmental skills
7. To provide transport for those hard to reach mothers and ensure that there are equal opportunities for all mothers to attend (Cabinet Office, 2006)
8. To provide an atmosphere of caring, compassion and safeness that embraces all the six Cs (care, compassion, competence, communication, courage and commitment) that are integrated within the National Health Service delivery of care (Chambers, 2013)

3. HISTORY OF ELPITHA

2008 Home-Start (Sue Drake) requested the assistance of health visitors in the running of a group to help postnatally depressed mothers in the Harlow area, Essex. Two health visitors (Helen Elia, Pat Alexander) volunteered and went on to write a six week course based on Compassionate Cognitive Behavioural Therapy (CCBT). Helen has a counselling qualification and Pat was working towards her MSc. in cognitive behavioural therapy at that time

2008 The group was launched by Home-Start and the two health visitors in December 2008 with 8 mothers attending and very positive feedback both qualitatively and quantitively. Since this time the group has taken place twice a year during the months of June/July and November/December

2012 A CBT Supervisor (Noel Sawyer) was contracted in to support the facilitators running the group for two sessions of two hours duration following sessions two and four

2012 The group was originally named the Stepping Stones Support Group but this was changed to the Elpitha Support Group in order to avoid confusion, as this name has been adopted by many other groups with differing purposes. The name 'Elpitha' was the brainchild of Helen and means 'hope' in the greek language. We thought that the name was appropriate for the group as its purpose was to instill hope with all those who attended. The name would also help to remove any stigma around attending such a group and help to retain its unique identity

2013 Presentation at the Annual General Meeting of Harlow Home-Start by a former participant of the Elpitha group

2013 Publication in the Nursing Times 16.10.13/Vol. 109 No. 41 "CBT-based support groups for postnatal depression"

2013 Presentation at the Communities of Practice Essex Event organised by Health Education East of England

2015 Presentation to the Maternity Services Liaison Committee, Harlow, Essex

Keywords: Postnatal depression/ Motherhood/Peer support groups/ Cognitive behavioural therapy
This article has been double-blind peer reviewed

Cognitive behavioural therapy techniques helped to create a postnatal depression support group that improved self-esteem and made mothers feel safe and supported

CBT-based support groups for postnatal depression

In this article...

- Discussion of CBT techniques used in a support group for mothers with postnatal depression
- Feedback from the groups
- Suggestions for developing similar groups

5 key points

1. Postnatal depression can have a detrimental effect on mother and child bonding
2. CBT-based support groups can help to alleviate the postnatal depression and teach long-term coping strategies
3. CBT techniques can help patients to recognise the relationship between thoughts and behaviours
4. Extending warmth and acceptance to others helps to reduce people's own feelings of isolation
5. Fathers also experience postnatal depression and may benefit from similar approaches

Author Pat Alexander is a senior health visitor and community practice teacher at South Essex Partnership Trust.

Abstract Alexander P (2013) CBT-based support groups for postnatal depression. *Nursing Times;* 109: 41, 12-14.
Postnatal depression can have serious implications for mother/child bonding and damage relationships between parents. Approaches to treat it need to overcome barriers that have led to high attrition in some group or clinic-based postnatal depression treatment studies.

This retrospective evaluation explored the benefits of offering postnatally depressed mothers group support based on cognitive behavioural therapy. It helped to improve women's self-esteem and self-worth and to make them feel safe and supported.

Postnatal depression has serious implications for mother/child bonding (Bowlby, 1951) and is detrimental to relationships between parents (Bancroft and Ardley, 2008).

New approaches to postnatal depression treatment need to overcome barriers to it such as stigma, lack of transport and childcare, and high attrition rates that have been found in some group or clinic-based postnatal depression treatment studies (Dennis and Hodnett, 2009).

A course of six group sessions were set up by a charity, which invited representatives of the NHS to work with it in addressing the needs of mothers with postnatal depression. The framework for the sessions was created by two health visitors, one undergoing further training to become a CBT therapist and the second who had counselling experience.

The framework relied heavily on Milgrom et al's (2006) work relating to using CBT principles to work with postnatally depressed women in community groups, and the compassion-focused work of Gilbert (2006).

All referrals to the support group came from health visitors and were directed through the charity, which managed the project's administration.

Compassionate CBT

The following gives an insight into how compassionate CBT is used in the group sessions and at individual contacts outside the weekly meetings.

Building trust

Each woman receives a home visit before joining a new course, and is given a letter offering information about it. She is reassured by the facilitator that she will be cared for and listened to but if she wishes to remain silent, that is acceptable too.

We explain that a taxi will be provided if she has no transport and that a creche is available. We also promise that we will be there at the main entrance to welcome her on the first day as many mothers feel isolated, frightened and vulnerable at this time.

Each mother is telephoned the day before the course starts to help her feel that her presence is valued and to offer an opportunity to discuss any concerns she may be experiencing. These phone calls continue throughout the course between each session. This approach helps the

TABLE 1. **SUMMARY OF FEEDBACK FROM SUPPORT GROUPS**

Topics	**Themes** Feelings and thoughts expressed by participants	**No of supporting responses** From 30 questionnaires
Previous low self-esteem	Loneliness, depression and tearfulness	15 (50%)
	Fear of speaking out	11 (36.6%)
	Anxiety, worry and self-failure	4 (13%)
Positive feelings gained	Gratitude for the group experience	20 (66.6%)
	Not being alone 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 feelings	9 (30%)
	Possessing the ability to look at life positively	9 (30%)
	Maintaining contact with friends made in the group	8 (26.6%)
Learnt from course	Understanding oneself and others better	15 (50%)
	Practising what has been learnt	14 (46.6%)
	Being able to deal with stressful situations	14 (46.6%)

facilitators to build a relationship of trust with each group member.

These simple actions help the women to feel safe and protected and challenge any entrenched negative beliefs they hold in relation to their self-worth.

The use of language

The language used in the sessions is accepting and non-judgemental. When group members express negative thoughts or emotions, these are listened to and acknowledged before being explored by the wider group, with the permission of the individual concerned. In this way, positive elements such as courage, perseverance and dedication are recognised, increasing the women's self-esteem through peer support.

During all sessions the word "we" is used in place of "you". This language helps to unite the facilitators and group members and bring a sense of wholeness to the sessions. We also regularly use the term "I'm doing the best I can" to soften the self-critical thoughts of "I am a failure" or "I'm not good enough" and to address perfectionist tendencies gradually.

Language is kept uncomplicated to be accessible to all group members. Educational aids are restricted to a flip chart to maintain simplicity and spontaneity.

CBT techniques

The group feed back each week on their experience of doing or trying to do any tasks they have been set between sessions. Facilitators are set the same tasks and feed back to group members; this approach helps to minimise the "them and us" divide and encourage group members to share their experiences and thoughts.

Session one is often emotional as we look at experiences before, during and after birth and the expectations of the mother during this time. During this session, most group members begin to realise they are not alone. The need for gentleness, acceptance and valuing is crucial as we acknowledge and explore negative emotions. We use words such as "walking the path together" and talk of the "uniqueness" of each member present to help develop a sense of belonging to the group.

Our homework following the first session is for the mothers to try to carry out one small activity that they used to find pleasurable. This ends the session on a positive note.

Session two involves looking at the relationship between thoughts and behaviour. We use a simple role play to create an awareness of how individuals react to the same situation in different ways depending on their state of mind. This awareness is then accompanied by looking at the depressive spiral and how we can develop tools to help prevent ourselves from becoming depressed. These techniques could include speaking to friends or reassuring yourself. The compassionate element of "being kind or gentle to ourselves" is a philosophy that underpins every session and the facilitators offer personal examples to demonstrate this where appropriate.

Sessions three to five involve the recognition of stress within ourselves, followed by basic relaxation techniques. Role play is used to demonstrate assertiveness, aggression and passiveness using everyday examples from motherhood and the use of a positive data log, which we call "my book" in session.

The positive data log, carried out during the fifth session, continues to build on the compassionate CBT approach and to challenge low self-esteem. Each group member has a personalised note book that is passed to other members of the group so they can write a few words to describe what they like about the person. The completed notebooks are returned to their owners and taken home to be read. The contents of the notebooks remain private to each individual. Feedback from past groups has shown that this exercise creates feelings of being soothed and safe. For some mothers, these words are the only written form of praise or friendliness they have ever received. The mothers are encouraged to continue to use this notebook at home to write positive notes, and it becomes a part of their toolkit to prevent low mood.

At the sixth and final group session, further support is offered in a variety of ways, such as a reunion after the sessions are over, a home visiting volunteer, attendance at family group or the option to make arrangements for one-to-one counselling.

Feedback

We used an evaluation form to collect qualitative data at the final session of each group. The form included general questions phrased both positively and negatively to offer a reasonable balance and to reduce "acquiescence bias", where participants have a tendency to agree regardless of the question's intent.

In total, 30 questionnaires were collected, leading to 13 themes being identified relating to feelings and thoughts. These themes were classified further under three topic areas:

- Low self-esteem;
- Positive feelings;
- Learning.

Table 1 offers a detailed picture of the responses received.

Discussion

Low self-esteem

Feedback from the completed questionnaires (Table 1) showed that 50% of the participants were experiencing feelings of loneliness, depression and tearfulness and 37% expressed a fear of speaking out.

Positive feelings

The Department of Health (2010) refers to the importance of feeling cared for and considers compassion to be a vital elements of positive patient care. 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 (Goleman, 2004). It was therefore interesting to note the effect the compassionate-focused CBT group had on the women attending.

The following quotes have been extracted from the participants' responses to the questionnaires.

Kindness to self:

"Coming to the course has helped me be gentle with myself."

Kindness from others:

"It's nice when someone actually cares about our feelings, makes us feel worthy."

Kindness to others:

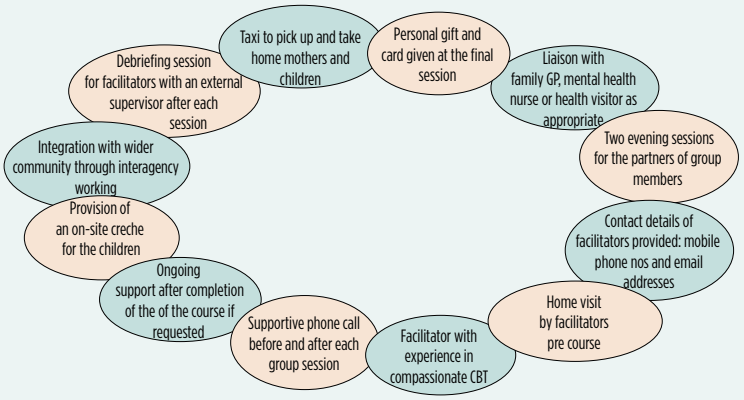
"This course is wonderful. I hope many others benefit from it in the future."

In addition to the theme of kindness, participants expressed coming to terms with their feelings and an increased ability to have fun and enjoy friendships.

"I have been laughing and smiling so much more and noticing and enjoying things a lot more."

"Now the course is finishing I will be friends with these lovely ladies."

FIG 1. **ELEMENTS OF THE SUPPORT GROUP COURSE**



Gilbert (2006) describes how the feelings associated with offering compassion can counter feelings of isolation.

Learning

The participants also remarked on how the course helped them to learn about themselves and others.

"Coming to the course has helped me be understanding towards others."

"Coming to the course has made me feel happy about myself."

"Now the course is finishing I will remember to use some of the tools that I learnt about when I most need them."

These expressions of awareness and empowerment show participants benefitted in both the short and the long term from the group, by learning to look to the future and use learnt techniques to deal with life stressors as they arise.

Conclusion

The findings in this evaluative study suggest that CBT-based support groups can be effective in alleviating the symptoms of postnatal depression and teaching long-term coping strategies. Evaluation showed a focus on compassion enabled group members to develop self-kindness and experience the feeling of being cared for.

The elements of the course (Fig 1) are supported by the demands of recent government reports. For example, by offering early targeted support for emotional and mental health problems in the postnatal period, we are helping children to have a good start in life (Cabinet Office, 2006). This supports the long-term aim of setting up similar groups elsewhere in the UK.

Recommendations for practice

Due to the group's anonymity, it has not been possible to carry out follow-up contact to identity long-term benefits. It would be helpful to run future groups with follow-up as part of the study so that this could be explored.

We also feel it would be beneficial, in view of the recognised problem of paternal depression, to offer support to the partners of postnatally depressed mothers (Bancroft and Ardley, 2008). Milgrom et al (2006) offers an outline of a programme to include fathers in a couples' support group that could serve as a helpful template for partner involvement in the future. The 2012 support groups have incorporated two evening sessions that partners can attend separately.

This evaluative study only involved postnatally depressed women and it may be useful to broaden support in the future to include the antenatal period, adopting a compassion-focused approach in an individual or a group setting. **NT**

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4. RELEVANCE OF ELPITHA IN TODAY'S WORLD

The prevalence of postnatal depression (PND) is one mother in 10 within the first postpartum year and that even higher rates occur in areas of deprivation (Cox, Holden, Henshaw 2014)

There is clear evidence that chronic maternal stress may significantly affect the infant's developmental outcomes (Talge, Neal, Glover 2007)

Paternal depression rates are double the national average for men in the same age group in Denmark (Madson, Juhl 2007) and the United States of America (Paulson, Daubers, Leiferman 2006)

A report produced by the London School of Economics and the Centre for Mental Health charity, commissioned by the Maternal Mental Health Alliance (MMHA), which groups together dozens of campaigning and professional bodies connected to the issue, states that substandard mental health care for pregnant women and new mothers is creating long-term costs of more than £8 billion every year

The MMHA also states that, while talking therapies are seen as especially useful for milder cases of perinatal depression, there is currently capacity to treat just 15% of women in England who need such services (Walker 2014)

5. SIGNS AND SYMPTOMS OF DEPRESSION

What helps to keep the depression going?

Veale et Willson (2007) provide **styles of thinking** that characterize depression:

Fortune telling: Negative and pessimistic predictions about the future, for example, 'I'll never get over this'

Mind reading: Jumping to conclusions about what others are thinking, for example, 'She thinks I'm boring'

Catastrophizing: 'Worst case' thoughts and images that enter the mind, for example, concluding that something terrible has happened when a loved one is late coming home

All-or-nothing thinking: Sometimes called 'black-or-white' thinking. This refers to thinking in extreme terms like: 'I should do something perfectly or not bother at all'

Demands: Rigid rules placed on oneself and others: 'must', 'should', 'have to' and 'ought' are all words that often involve inflexible demands which may not help in accepting or adapting to reality

Personalizing: Taking other people's actions too personally, or placing too much responsibility on oneself for a negative event

Mental filtering: Focusing on the negative events in one's life or on one's failings, and ignoring the positive elements or one's positive attributes

Disqualifying the positive: Taking information that could be interpreted as positive and discounting or distorting it, for example 'That doesn't count; They're only saying something nice because they pity me'

Emotional reasoning: Thinking the way one feels indicates how things are in reality, for example, 'I feel I'm a hopeless case, therefore it's a fact'

Fusion: Similar to emotional reasoning. To 'buy into' thoughts (with their related memories and feelings) like they are facts i.e. 'fusing' thoughts with reality

Labelling: Globally putting yourself, others, or the world down, for example, 'I'm a failure', 'I'm useless', I'm worthless', 'He's so stupid', 'She's a horrible person', 'People are nasty', 'The world's a terrible place'

Overgeneralizing: Drawing a general conclusion from a specific event, 'Always' and 'Never' statements are common, for example, when the car refuses to start and one thinks 'Nothing ever goes right for me'

Frustration intolerance: Telling oneself that a difficult experience is 'unbearable', 'intolerable' or that you 'can't stand it'

Awfulizing: Labelling a 'bad'event as 'terrible', 'awful', or 'the end of the world'

6. CAUSES OF DEPRESSION AND PERINATAL DEPRESSION

The causes are many, complex and often inter-related being shared between both depression and perinatal depression

GENERAL DEPRESSION

Isolation, Self-Criticism,
Inactivity

PERINATAL DEPRESSION

Withdrawal from friends, Lack of interest or over-concern for baby, mood swings

SOCIAL CONTEXT (Negative life events)

Bullying, Neglect,

Broken relationship, Loss

Miscarriage, Stillbirth

Loss of mother or poor relationship
Domestic violence, Stressful partnership

PSYCHOLOGICAL FACTORS

Low self-esteem, Perfectionism

Anxiety, Dependency

Poor self-image, Loss of self identity

Feelings of worthlessness or guilt

Thoughts of suicide or death

PHYSICAL CAUSES OF VULNERABILITY

Genes (family history of depression)

Biology (neurological condition e.g. chronic pain)

Difficult pregnancy, labour or delivery

Change in appetite or weight

Difficulty sleeping or oversleeping

Fatigue, Loss of energy, Loss of libido

Difficulty concentrating, Agitation

6. CAUSES OF DEPRESSION AND PERINATAL DEPRESSION *(continued)*

The symptoms and fears surrounding perinatal depression 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 perinatal depression takes hold.

'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 postnatal depression – it was me, my fault, my problem. I had no professional support and no hope of getting better in the foreseeable future.

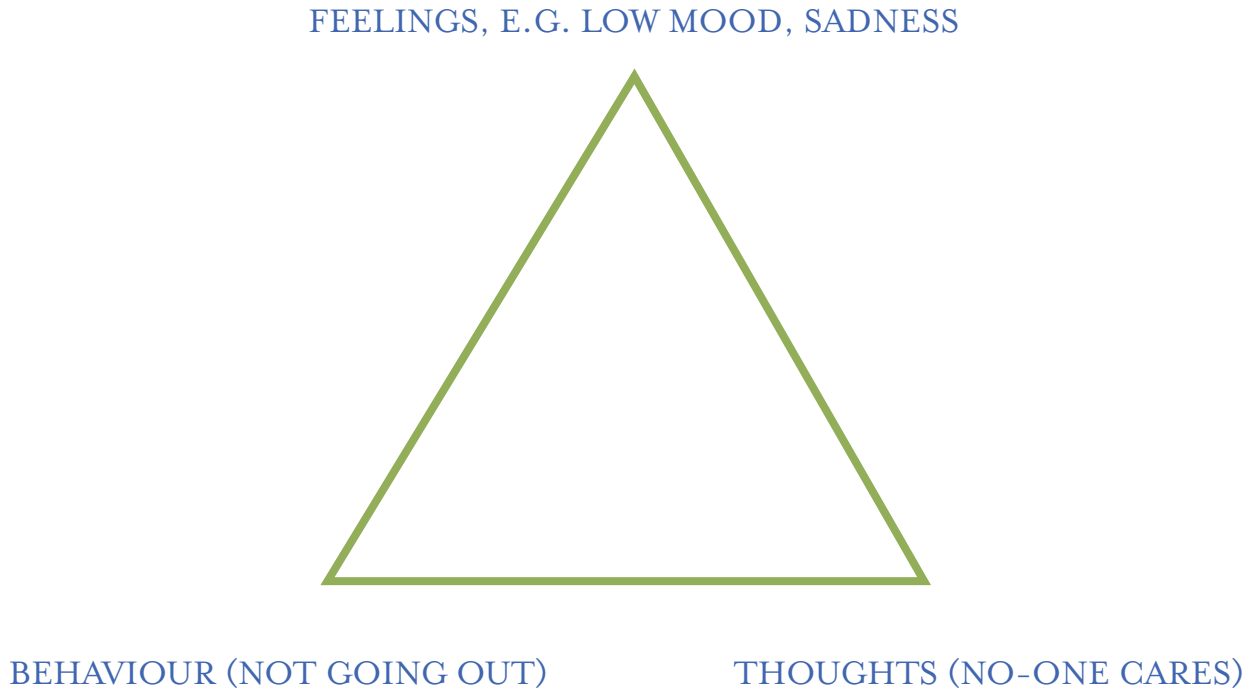
I then began to suffer from feelings of enormous guilt – the lack of bonding with my baby. I had bonded better with my dog and my rabbit – immediately. Why, so many months down the line, had I not bonded with my own flesh and blood? I wanted to take my child, dump her and run. I never wanted to harm 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

7. WHAT IS COGNITIVE BEHAVIORAL THERAPY?

Today Cognitive Behavioural Therapy (CBT) is 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.

It has been recognized by the National Institute of Clinical Excellence (NICE, 2009) that CBT is an effective treatment for negative ways of thinking due to the fact that CBT helps the person towards changing their way of thinking (cognition) and their actions. The relationship and interaction between behaviour, thoughts and feelings is illustrated in the diagram below.



Behaviour, thoughts and feelings all interact with each other (Beck J. 2005)

8. WHAT IS COMPASSIONATE COGNITIVE BEHAVIOURAL THERAPY?

"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 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. 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).

Shame

Shame has been associated with depressive disorder and there is evidence that **those who are highly self-critical do less well with traditional CBT** (Rector et al 2000, cited by Westbrook, Kennerley et Kirk, 2007), the possible reason being due to the long standing negative schema or constructs (a stored body of knowledge of how each one of us interprets the world and those around us). Compassionate Cognitive Behaviour Therapy (CCBT) works towards helping those with internal shame, self-criticism and self-condemnation to develop inner compassion and warmth. This act of self-compassion helps to gradually reduce feelings of shame and acts as a method of self-soothing when self-attack occurs (Westbrook et al 2007). Self-compassion also helps to slowly readdress any longstanding negative schema or construct which is mentioned above.

Compassion and Disclosure

Gilbert (2006) expresses how compassion helps us to attune ourselves to the significance of the personal struggle that may be experienced by people attending therapy (especially in a group setting), to disclose their inner experience and to risk new behaviours both in and outside sessions. An acknowledgement and appreciation of such risk-taking on the behalf of the facilitator helps to convey both respect and encouragement for future engagement and self-exploration by the participant, at the same time creating an atmosphere of trust.

Key Attributes of Compassion (Gilbert, 2009)

EMPATHY NON-JUDGEMENTAL DISTRESS TOLERANCE SENSITIVITY CARE FOR WELL-BEING SYMPATHY

COMPASSIONATE ATTRIBUTES

Motivation to be more caring of the self and others

Sensitivity to the feelings and needs of the self and others

Sympathy, being open and able to be moved, and emotionally in tune with our feelings, distress and needs and those of others

The ability to tolerate rather than avoid difficult feelings, memories or situations

An empathic understanding of how our mind works, why we feel what we feel, how our thoughts are – and the same for others

An accepting, non-condemning, and non-submissive orientation towards ourselves and others

COMPASSIONATE SKILLS

Deliberately focusing our attention on things that are helpful and bring a balanced perspective

Mindful attention and using it to bring to mind helpful compassionate memories, images and/or a sense of self

Thinking and reasoning, using our rational minds, looking at the evidence and bringing a balanced perspective

Writing down and reflecting on our styles of thinking and reasoning

Planning and engaging in behaviour that acts to relieve distress and moves us (and others) forward to our (or their) life goals - to flourish

(Gilbert, 2010 p. 236)

9. GROUP THERAPY

a. *Benefits of group therapy*

- Peer group support (no longer feeling alone and isolated)
- Development of kindness towards themselves and others (improves quality of relationships with children, partners, extended family and the wider social network)
- Partnership working between health and the Home-Start charity
- Raising of self-esteem of the participants, helping them to rediscover their 'lost-self'
- Decrease in anxiety through adopting a compassionate approach both to themselves and to others
- Adoption of strategies to cope with future stressful and challenging life events
- Assists in building community capacity by enabling involvement in other groups, training and employment
- Helps to save money due to decreased dependence on the General Practitioner and the Mental Health Services with some participants
- Compliments the Family Partnership Model which has been adopted by various Health Visiting teams throughout the country
- Westbrook et al (2007, p.230) notes other benefits to be:
- Normalising group members' experiences, as the symptoms and problems of others are shared
- Clients can often spot in others what was not obvious in themselves e.g. increased ability to recognise links between thoughts and feelings
- Group support for doing difficult tasks e.g. tasks outside the group where courage is needed
- Development of a culture of homework (task) completion
- Potential for group members to act as co-therapists for each other by offering empathy

b. Disadvantages of Group Therapy

- Following items taken from group work notes of Westbrook et al (2007, p.230)
- Possible reluctance to disclose shameful beliefs
- Risk of one or a few individuals monopolising the sessions
- Different improvement rates among the group may be discouraging for some
- Potential for unhelpful culture to develop e.g. off target discussion

c. Group Numbers

Bieling, McCabe et Antony (2009) comment that, when groups exceed 12 members, participants have little time to speak or listen to one another so that it becomes difficult for group cohesion to develop. Group members need to attain a certain level of familiarity with one another's narratives and situations to feel comfortable asking questions or offering important expressions of support. For the Elpitha group the maximum number is always kept to 12 for these reasons.

d. Difficulties encountered during group work

THE TALKATIVE PARTICIPANT

Listen to their story but find an appropriate moment to say:

"Thank you so much for sharing your thoughts/experiences with us, may I just ask if anyone else would like to share their thoughts/experiences"

Or

"That is really interesting, may we just remember this important point and come back to it later" .....then carry on with the topic (and note the point on the flip chart)

Or

"Thank you so much, may I just stop you there and ask if anyone would like to share their thoughts on this issue?"

THE VERY QUIET PARTICIPANT

Accept this but, at the end of each session, go round each member and ask for their individual ideas regarding the homework that is set between each session. If they say "I don't know" then say "Have a little think and I'll come back to you" as you continue to go around the group. If the participant still has no ideas then offer a very simple task for them to think about doing during the week.

Also, at the beginning of each session, you may ask members individually if they have any feedback from the last session's topic and any feelings about it. They may just say "no" which is fine and care needs to be taken not to make them feel exposed or threatened.

THE ONE WHO LEAVES THE ROOM CRYING

There are three group facilitators in the group, two sharing the leading of the sessions and one who is an observer. One of the roles of the observer is to leave the room with the participant who is crying in order to sit with them. The participant may need to weep for some time and have the comfort of an understanding and silent companion next to her. The participant may then need to share the reasons for her upset before she feels ready once more to return with the observer to the main group.

THE ONE WHO REMAINS IN THE ROOM CRYING

In this situation the participant is feeling a mixture of embarrassment, grief, failure and isolation and it is important, most of all, to reassure her that she is safe and how much we appreciate her having the courage to share her sadness with us. The first way of dealing with this sensitive situation is to approach her gently, to offer her a tissue, to touch her hand or give her a hug (with her permission), whichever way that you feel most comfortable with.

If appropriate, you may ask other members of the group to offer their own wise words "Is there anything that we may say to ….. to make her feel a little better?" It can be quite amazing to hear the compassionate words of the other members of the group.

At this point the participant may well have reached a very low point in her moods and needs to be comforted by reassuring her that slowly, slowly, as the weeks pass by, the sessions may help to lessen the deep pain that she is feeling and help her to gently move forward in her life.

THE VERY NEGATIVE OR CRITICAL MEMBER

For this member we call it 'black and white' thinking, it is difficult for the participant to see any 'grey' or any way out of what they feel is a hopeless situation. In this case, listen to part of the story but, at an appropriate time, comment:

"Thank you so much for sharing part of your story/feelings with us.

Is there any other way we may look at this difficult situation?"

Offer one's own ideas

Ask for the group's ideas

Use the 'best friend' scenario i.e. what would the participant say to reassure a close friend (to help her step out of the situation and become more objective as well as to develop a sense of compassion and hope)

Acknowledge the courage to speak, to come to the group, create some feeling of positivity and gently moving forward

THE ONE WHO FEELS HOPELESS OR USELESS

With the participant who feels hopeless or useless, it is enormously comforting and accepting to offer compassionate listening with empathy, to come alongside the participant and to look for the positives, no matter how small, acknowledging the special personal attributes of the person.

10. LEADERSHIP SKILLS

COMPASSION IN THE GROUP SETTING

"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." (Gilbert, P. 2006 p.373)

"Successful therapists generally possess an especial capacity for identifying with the insulted and the injured … psychotherapists often have some personal knowledge of what it is to be insulted and injured, a kind of knowledge they would rather be without, but which actually extends the range of their compassion" (Stort, 1979 quoted in Gilbert P. 2006 p. 382)

SUPPORTING OURSELVES DURING GROUP SESSIONS AND DEALING WITH CONFRONTATIONS

In our groups there are always at least two facilitators and, if possible a third, who acts as a support should a mother leave the room for a short period due to becoming upset in session. This third person is also able to observe members of the group and offer important feedback regarding reactions that may have gone unnoticed by the facilitators (Gilbert, 2006 p. 383)

Openness, trust and a certain amount of fluidity during sessions is essential among the facilitators of the group to avoid any negative feelings of competitiveness or self-doubt. It is important to have discussions pre and post each session to ensure that an atmosphere of mutual understanding and support is maintained in addition to two sessions following group two and four from an external supervisor at which time discussions in greater depth may take place in relation to clients or issues that the facilitators may be struggling with.

Therapists need to equip themselves with a philosophy that embraces both the inevitability of suffering and the inherent resilience of human beings to overcome life's obstacles and challenges (Gilbert, 2006).

COMPASSION TOWARDS OURSELVES AS FACILITATORS

As facilitators of the Elpitha support group, compassion is one of the main qualities that is needed, in addition to basic cognitive behavioural therapy skills. However, what may occur sometimes is that we experience emotional, mental and physical exhaustion as a result of offering endless compassion to others and by forgetting the care of ourselves in the process.

In this respect it is helpful for us to study the following strategies which have been used by others in the caring professions to help them to avoid burn out and to continue offering the best quality care.

EXTRACTS OF INTERVIEWS WITH WOMEN WHO HAVE MADE A SIGNIFICANT CONTRIBUTION TO THE COGNITIVE BEHAVIOURAL THERAPY COMMUNITY

(Murphy, P. (2014) Changing the Game. British Association for Behavioural and Cognitive Psychotherapy (BABCP), 42/03 (13-20)

QUESTION: WHEN THINGS GET TOUGH, HOW DO YOU KEEP YOURSELF GOING?"

DR. MARY WELFORD, CLINICAL PSYCHOLOGIST AND FOUNDING MEMBER OF THE COMPASSIONATE MIND FOUNDATION:

"Thankfully I can turn to colleagues, family and friends. These days I also choose self-compassion rather than hostile self-criticism. In doing this I recognise that things are difficult, rather than undermining myself, and look towards the future instead of ridiculing myself about the past.

I have a number of other 'props' to help me. For example, I have a necklace that says 'my life, my rules' that I wear when I feel I need the courage to stick to my principles or ethics. I write to myself, sometimes letters, sometimes single words on my hands. I listen to specific pieces of music or go and look at a vista in order to help me gain a sense of greater perspective on things."

DR. DEBORAH LEE, CLINICAL PSYCHOLOGIST, HEAD OF BERKSHIRE TRAUMATIC STRESS SERVICE, BOARD MEMBER OF THE COMPASSIONATE MIND FOUNDATION:

"I just keep going as I do not want to let people down, I have a strong sense of duty and the good fortune to be able to call on friends when in need.... I remind myself I am doing what I can to be the best I can be and I accept that, at times, I am not firing on all four cylinders because other things are going on in my life. But I also use my dear friends, family and professional colleagues when I need support, reassurance and advice. When you work in trauma, it is important to make sure you remember that human beings are amazing too, hugely creative, inspiring and capable of great things."

QUESTION: "WHAT ARE THE ATTITUDES THAT HELP TO KEEP YOU BALANCED?"

DR. MARY WELFORD:

"There but for the grace of God go I

Remember what matters

Don't be a sheep

To thine own self be true

… Another further perspective that helps me is my belief that we are all part of the flow of life. To me this means we are all connected. It ensures that I neither feel isolated or get above my station."

DR. DEBORAH LEE:

"Well, I am a firm believer in evolution. Everyone is equal, no-one is better than another, and that people can change their lives. Life is random, no-one is special or better, we are all doing what we can to survive the challenges of life, and we all suffer. So we have more in common than we have difference."

POINTS TO REMEMBER

"WHEN WE COMMUNICATE:

7% of what we say is the words

38% is the way in which we say it (tone)

55% is the unspoken word, often referred to as body language

The unspoken word is powerful … the two key elements are congruence and conviction. Congruence is when what you are saying matches the way you are saying it, along with your non-verbal gestures, such as positive eye-contact. If you are congruent, you're authentic and believable. Conviction is developed through all these stages."

Oshikanlu, R. (2014) Gaining influence in the boardroom. Nursing Times

ELPITHA TRAINING MANUAL

FOR GROUP WORK WITH MOTHERS OF LOW MOOD

Elpitha: 'hope' in greek

ACKNOWLEDGEMENTS:

Sue Drake, retired Home-Start Co-ordinator Harlow
(who conceived the idea of a group run in partnership with
Home-Start and the Health Visiting team for mothers of low mood)

Helen Elia and Pat Alexander, Health Visitors
(who created the Elpitha course together)

Claire Strudwick and Val Evans Home-Start Co-ordinators,
Harlow for their dedication and encouragement to roll the
group out to a wider audience

All Home-Start staff and volunteers at the Harlow branch for
their wholehearted commitment towards the running of the Elpitha group

Noel Sawyer, Cognitive Behaviour Therapist and Supervisor
for his on-going support and guidance

PRACTICAL PREPARATIONS

Referral forms to professionals

A referral form is sent to the nurse manager who forwards this on to the health visiting teams three months before the commencement of the group, including a cut off date six weeks prior to the commencement date.

A meeting takes place following this cut off date between the facilitators of the group and the Home-Start team in order to discuss the referrals and to establish a priority list for home visiting pre group.

Selection of group participants through Home visits pre group

All referrals receive a home visit to discuss attendance or alternative options to support the mother (e.g. Home-Start family group). At this visit the PHQ-7 (patient-health questionnaire) and GAD-7 (General anxiety disorder) are completed which form part of the pre and post evaluation procedure.

A text is sent to the mother's mobile phone to confirm her place on the group and to offer her a contact number regarding any future queries. This is followed up by a phone call from Home-Start to enquire if a crèche place and/or transport are needed.

Pre-Course Preparation

A folder is provided for each participant with their first name printed in italics on a sticky label on the front cover, which the participants use to place their handouts in. This helps to make each mother have a sense of belonging to the group and to begin to feel valued as an individual.

Inside the folder is a 'Welcome' sheet with the names and contact mobile numbers of the facilitators plus the main Home-Start contact number, in order that contact may be made by phone or text between group sessions. For example, they may wish to discuss a matter that is causing them concern in between group sessions or book or cancel a crèche place or taxi.

Pre each session

Handouts for the relevant session

Vouchers for free tea/coffee/soft drinks

Fruit (e.g. grapes) and sweets (e.g. chocolates) on a round table in the centre of the room with the chairs in a circle around the table

Flip chart with felt tip pens (everything is interactive, face to face and technology free)

Pre session 5

Biros for each participant

A small notebook (approx. 10 cms. by 14 cms.) with the first name of each participant printed in italics on a label adhered to the front cover

Bucket or similar container (for the 'Survival Bucket' part of the session)

Loose pieces of paper which can be written on, folded and placed in the 'Survival Bucket'

Pre session 6

Framed "The Beautiful" poem by Elizabeth Kubler-Ross

Certificate of Attendance with their name on

Gift of Bubble bath and candle

Evaluation forms for completion at the beginning of the session (PHQ-9, GAD-7 and an open-ended questionnaire for free writing) See Supplementary documentation

2. COSTS INVOLVED IN RUNNING THE ELPITHA SUPPORT GROUP

Room hire

Crèche run by Home-Start volunteers

Refreshments for six sessions

Leaving presents for the final session

Taxi service for those with transport difficulties

Folders/materials for group participants

Administration time for arranging the above

Fundraising time by the Home-Start co-ordinator

Supervisor support for facilitators of the group (2 sessions following the second and fourth sessions of two hours duration)

Facilitators' time input:

Home visits pre group; group sessions and the production of hand-outs for each session; attendance at supervision sessions x two; evaluation analysis post group; feedback to referrers and funders; preparation of materials and the room pre commencement of each session; occasional support of some group participants in-between sessions through telephone support or a home visit

Observor's time input:

In addition to the two facilitators, there is the important role of the silent observer who is there to comfort mothers should they become upset and leave the room. The silent observer is also often aware of the reactions of other members of the group that the facilitators may miss when running the group. This feedback helps to provide a deeper understanding of group dynamics and the feelings of group members that may be discussed post session or during supervision.

It is also the role of the observer to phone or text mothers inbetween group sessions for feedback and to offer any reassurance that may be needed. The observer may participate to a small degree in the group but such participation is spontaneous apart from the initial session when introductions are given and housekeeping is explained. The observer also explains about the role of Home-Start at the final session in relation to moving forward and future support and groups that are available.

3. TIME SCHEDULE

Countdown

- **12 weeks before**: health visiting teams are informed of the forthcoming group via an e mail with referral forms attached, an explanatory letter regarding the purpose of the group for clients to read plus a cut-off date for the acceptance of referrals 6 weeks prior to commencement

- Room booking

- **6 weeks before**: meeting after cut-off date to prioritize referrals between Home-Start and the facilitators

- **6-2 weeks before**: home visits by facilitators to those who have been referred to the group, confirmation text sent to those mothers accepted on to the group by the visiting facilitator to provide contact mobile number

- **2 – 1 weeks before**: preparation of the group materials (attendance list, folders, handouts and letter to referrer to inform if their client is to attend the group)

- **1 – 2 weeks before**: selection of volunteers to run the crèche dependent on the numbers of children attending

- Booking of taxis for those requiring transport

- **Day before**: text to all participants regarding 'looking forward to welcoming you to the group' by facilitator who carried out the initial home visit and/or Homestart

- **Actual day**: greet each participant at the main entrance and guide them to the meeting room (providing a free token for a hot drink) or, if with a child, guide them to the crèche. Here the mother will meet her child's key worker who will help to settle her child into their new environment and reassure the mother

4. PRE ELPITHA HOME VISIT

Preamble — suggestions for content of the home visit

....Thank you for taking the time to see me

....Your health visitor has referred you to our group and I have come to answer any questions you may have

....I understand that it is scary/needs a lot of courage/is daunting ..... to attend a group when you are experiencing low mood but I hope that I may be able to reassure you that we will care for you and that you will feel safe

....We will expect nothing of you, you may speak if you wish or remain silent, we would just like you to join us for the six weeks, to rest for those two hours and hopefully become aware of different ways which will help you feel a little better

....One of the main feedbacks from our previous groups is that those who attended no longer felt alone

....Have there been any triggers in your life that you feel attributed towards your low moods?

....Thank you for sharing your thoughts and feelings with me. We shall be at the main entrance on the first day of the course to welcome you and will also text you the day before

....Here is my contact mobile/landline number should you wish to contact myself or Home-Start before the course begins

....Before I leave I should greatly appreciate if you could complete this questionnaire for me. We do this before and after completion of the group in order for us to evaluate if the course has helped a little (provide the PHQ-9 and GAD-7 to be completed)

ELPITHA GROUP WORK SESSIONS

Background information on cognitive behavioural therapy and compassionate cognitive behavioural therapy is provided as an addendum to each session

SESSION ONE:	HOPE
SESSION TWO:	TIME FOR MOM
SESSION THREE:	STRESSBUSTERS
SESSION FOUR:	BEING FIRM BUT KIND
SESSION FIVE:	BEING OURSELVES
SESSION SIX:	LOOKING BACK, MOVING FORWARD

THE USE OF LANGUAGE

The language used in the sessions is accepting and non-judgemental. When group members express negative thoughts or emotions, these are listened to and acknowledged before being explored by the wider group, with the permission of the individual concerned. In this way, positive elements such as courage, perseverance and dedication are recognised which work towards slowly building up the mother's self-esteem.

During all sessions the word 'we' is used in place of 'you'. This language helps to unite the facilitators and group members and to bring a sense of wholeness to the sessions. We also regularly use the term "I'm doing the best I can" to soften the self-critical thoughts of "I am a failure" or "I'm not good enough" and thus to gradually address perfectionist tendencies.

Language is kept uncomplicated in order to be understood by all group members. Educational aids are restricted to a flip chart to maintain simplicity and spontaneity.

Hope

Session 1

Elpitha Support Group

MASTER COPY ELPITHA SUPPORT GROUP

SESSION ONE

Housekeeping.

Fire exit – point out/assembly point, Toilets – please feel free to just get up and go!
At approximately 10.45am we will be taking a short break (approx 15 mins) for tea/coffee/ juice and a tasty treat.

The session will be finishing at 12 o'clock, we do aim to keep to times set, because we are aware you are busy and have other commitments. We will make sure that you leave with our/ Home-Start's contact numbers, should you feel that you wish to discuss anything before the next session.

There will be six sessions from 10 am – 12 noon. The dates are all in your packs.

Something very important, which I am sure we all agree with, is the importance of confidentiality. Anything we talk about, in this group, stays within our group. Perhaps we could think about what ground rules are important to us for our group (flip chart and write ideas down) e.g. mobile phones on vibrate or off; listen to each other, value each other.

Introduction

Firstly, we would like to thank you all for coming today, and we appreciate you attending. We understand that it's not always easy to ask for help. The fact that you have expressed a wish to be here is wonderful.

Icebreaker

So that we get to know each other a little better, we would ask you to introduce yourself to the person on your right, and just tell them your name and anything about yourself that you feel comfortable sharing with them. We will also be doing this at the same time, and at the end we will all take turns introducing each other.

Outline

In the course of the six weeks we have together in the group, we hope to help you develop some useful skills to deal with all the competing demands of motherhood and to identify some of the factors that influence your mood

As you learn these skills, we hope you will begin to develop a greater sense of control over your feelings, and to have more happiness in your life and relationships.

Supporting one another

It is important that everyone feels that they can talk openly in this group without fear of criticism or interruption. Some of you will feel comfortable talking in the group while others may take longer to feel free to express yourselves. We will be helping everyone to have equal time to speak. So, if you like to talk a lot, please don't be offended if we ask you to wind up so that someone else can be given an opportunity to speak. Alternatively, if you feel uncomfortable speaking up, we will gently encourage you, but you will not be compelled to talk if you do not wish to, it is good just to have you here with us.

Does anyone have any questions or anything to add?

What has brought us here today?

Perhaps situations and feelings which reach right back into our childhood or more recent ones related to loss or a broken relationship. Today we are going to have a look at our feelings around our pregnancy, labour and birth.

PREGNANCY, BIRTH, NOW

HANDOUT 1

Pregnancy experiences	eg	Planned/unplanned/problems
Birth experiences	eg	Complications Premature baby Baby in special care
Experiences now	eg	Crying baby Unsupportive family Feeling useless and lonely
Expectations	eg	A contented baby To feel happy and complete

'Our experiences of pregnancy, birth and early parenting are often nothing like we imagined or expected, even if this is not your first child. Every pregnancy, birth and baby is different and this can influence our early parenting experiences. We are interested in hearing your story and would like to ask if there is anything you would be happy to share with us about your pregnancy, birth and early parenting experiences.'

'IS THERE ANYONE WHO WOULD LIKE TO GET US STARTED?'

Use of the flip chart, write everything down and discuss the mother's current experiences and feelings to their previous expectations of pregnancy, birth and motherhood.
Tap into the mother's attitudes and beliefs about motherhood, for example, myths about what constitutes the 'good' or 'perfect' mother.

IF THE GROUP REMAINS QUIET THEN THE FOLLOWING QUOTES MAY BE READ OUT TO HELP THEM FEEL COMFORTABLE TO SPEAK. OTHERWISE READ THE QUOTES OUT AFTER THE SHARING SESSION TO HELP THEM REALIZE THAT THERE ARE MANY OTHERS WHO FEEL THE SAME AS THEMSELVES.

What other women say:

'I hate being pregnant, I was sick all the time.'

'Everything had to be perfect before the baby was born.'

'I hate being out of control.' (not just with children)

'I feel guilty if I'm at home and guilty if I am at work.'

'Having no routine is hard when I prefer structure.'

'There are so many things to be done, I feel guilty if I have time for myself.'

'My mother had eight children and coped and I want to be that way too.'

'I know I expect too much of myself.' (common with or without children)

'If I have an unsettled baby, it means I am a bad mother.'

'I spend so much time getting him settled that when he is content, I have no opportunity to enjoy him because I'm so tired and there is so much to do.'

TEA BREAK -

WHAT IS POSTNATAL DEPRESSION?/FEELING LOW

It sounds like there have been some difficulties for most of you in adjusting to your current situation. Everyone has a unique set of circumstances although you share the common experience of feeling low. So what is postnatal depression? What are some of the signs that a woman might be experiencing when she is feeling low?

We are aware that some of you have suffered from depression or low moods prior to having children and hopefully you can share with us any symptoms or signs from your experience of this.

To first use flip chart

(See handout 2)

Symptoms of postnatal depression

Symptoms of postnatal depression (PND) include:

- Low mood, sadness
- Feelings of worthlessness
- Tearfulness
- Self-blame or guilt
- Anxiety
- Irritability or emotional highs and lows
- Lack of energy
- Lack of interest in activities
- Increased or decreased appetite
- Reduced concentration and decision making ability
- Sleep disturbance (difficulty getting to sleep or staying asleep unrelated to the baby)
- Worries about own health
- Confused thought
- Slowed or fast speech
- Slowed movement or agitation
- Feelings of hopelessness
- Thoughts about death or suicide

What can help

The ideas in each culture about the "joys" of pregnancy and of "perfect" motherhood also have a powerful influence on us, often creating unrealistic expectations about pregnancy, birth and motherhood. Mothers who hold these expectations and beliefs often feel like "failures" when they experience problems coping, and depression is a common outcome. They often become very self critical using language like "I should" or "I must" rather than more gentle words such as "I may" or "I'm doing the best I can".

Depression after childbirth affects 10-20% of women.

We believe that depression occurs when there is an imbalance between positive events and negative events in your life. Depression is a signal that the balance has been upset, and the negatives outweigh the positives. It is also why on some days when something good happens you may feel better.

How we feel is one of the hardest things in the world to change. Has anyone had the experience of someone saying "Pull up your socks and get on with it"? Did it help? It didn't help you to feel better because our feelings are so closely linked with what we are doing and how we are thinking about the world. Without changing the way we think and what we are doing, it is very difficult to change how we feel. The aim of these sessions will be to help you tip the balance in favour of positives. Have you any ideas how you might do this?

Start with putting ideas on the flip chart

SESSION 1 HANDOUT 3

What can I do to feel a little better?

Doing activities which care for ourselves

Increasing pleasant activities with baby, family and friends

Learning relaxation skills

Improving assertiveness and communication skills

Building support networks

Increasing positive thoughts and decreasing negative ones

Looking at unhelpful ways of thinking

Finally:

Handout 4

POSITION AVAILABLE

Full time: long days, seven days a week, some time off in the evenings.

We are seeking a kind, considerate person for a challenging position. Qualifications and experience are not necessary, although you will be fulfilling some or all of the tasks of the following trained people: chef, teacher, nurse, childcare worker, taxi driver, organiser, counsellor and comedian.

THIS IS AN HONORARY POSITION BUT NEVERTHELESS A MOST IMPORTANT ONE!

THE POSITION IS FOR THE ROLE OF A MOTHER

Conclusion:Mothers are amazing people – no wonder they struggle at times.

ACTIVITY to do at home before next week: Do one thing for yourself that you used to enjoy and try and be aware of how you feel just **BEFORE** you do the activity and how you feel straight **AFTERWARDS**. This is to help you find out if there has been any change in your mood at all.

We look forward very much to seeing you all again next week. We are all around for the next 15 minutes if there is anything you may want to ask us or talk to us about. Alternatively you may ring or text us, our contact mobile numbers and Home-Start's landline number are in the front of the folder which you have been given this morning.

SESSION ONE

HANDOUT 1

Pregnancy experiences	eg	Planned/unplanned/problems
Birth experiences	eg	Complications Premature baby Difficult birth Baby in special care
Experiences now	eg	Crying baby Unsupportive family Feeling useless and lonely
Expectations	eg	A contented baby To feel happy and complete

SESSION ONE

HANDOUT 2

Symptoms of postnatal depression

- Low mood, sadness
- Feelings of worthlessness
- Tearfulness
- Self-blame or guilt
- Anxiety
- Irritability or emotional highs and lows
- Lack of energy
- Lack of interest in activities
- Increased or decreased appetite
- Reduced concentration and decision making ability
- Sleep disturbance (difficulty getting to sleep or staying asleep unrelated to the baby)
- Worries about own health
- Confused thought
- Slowed or fast speech
- Slowed movement or agitation
- Feelings of hopelessness
- Thoughts about death or suicide

SESSION ONE

HANDOUT 3

What can I do to feel a little better?

- Doing activities which care for ourselves
- Increasing pleasant activities with baby, family and friends
- Learning relaxation skills
- Improving assertiveness and communication skills
- Building support networks
- Increasing positive thoughts and decreasing negative ones
- Looking at unhelpful ways of thinking

SESSION ONE

HANDOUT 4

Position Available For A Mother

FULL TIME:
LONG DAYS, SEVEN DAYS A WEEK, SOME TIME OFF IN THE EVENINGS.

We are seeking a kind, considerate person for the challenging position of parent. Qualifications and experience are not necessary, although you will be fulfilling some or all of the tasks of the following trained people: chef, teacher, nurse, childcare worker, taxi driver, organiser, counsellor and comedian.

THIS IS AN HONORARY POSITION. !!

Conclusion:
Mothers are amazing people —
no wonder they struggle at times

5. COURSE CONTENT

SESSION 1: HOPE: SUPPLEMENTARY BACKGROUND INFORMATION

Session 1 is often emotional as we look at experiences before, during and after birth and the expectations of the mother at these times. During this session most group members begin to realise that they are not alone. The need for gentleness, acceptance and valuing is crucial as we acknowledge and explore negative emotions. We use words such as "walking the path together" and talk of the "uniqueness" of each member present to help develop a sense of belonging to the group.

Opening up

For many group members it takes tremendous courage to speak as they fear that they may be rejected for their thoughts and feelings. However, it is recognised that keeping secrets may also be psychologically damaging. One of the advantages of the compassionate group therapy may be the opportunity to make social comparisons and sharing negative thoughts about the self in an accepting and kind atmosphere that is non-judgemental (Tarrier, Wells et Haddock, 2008).

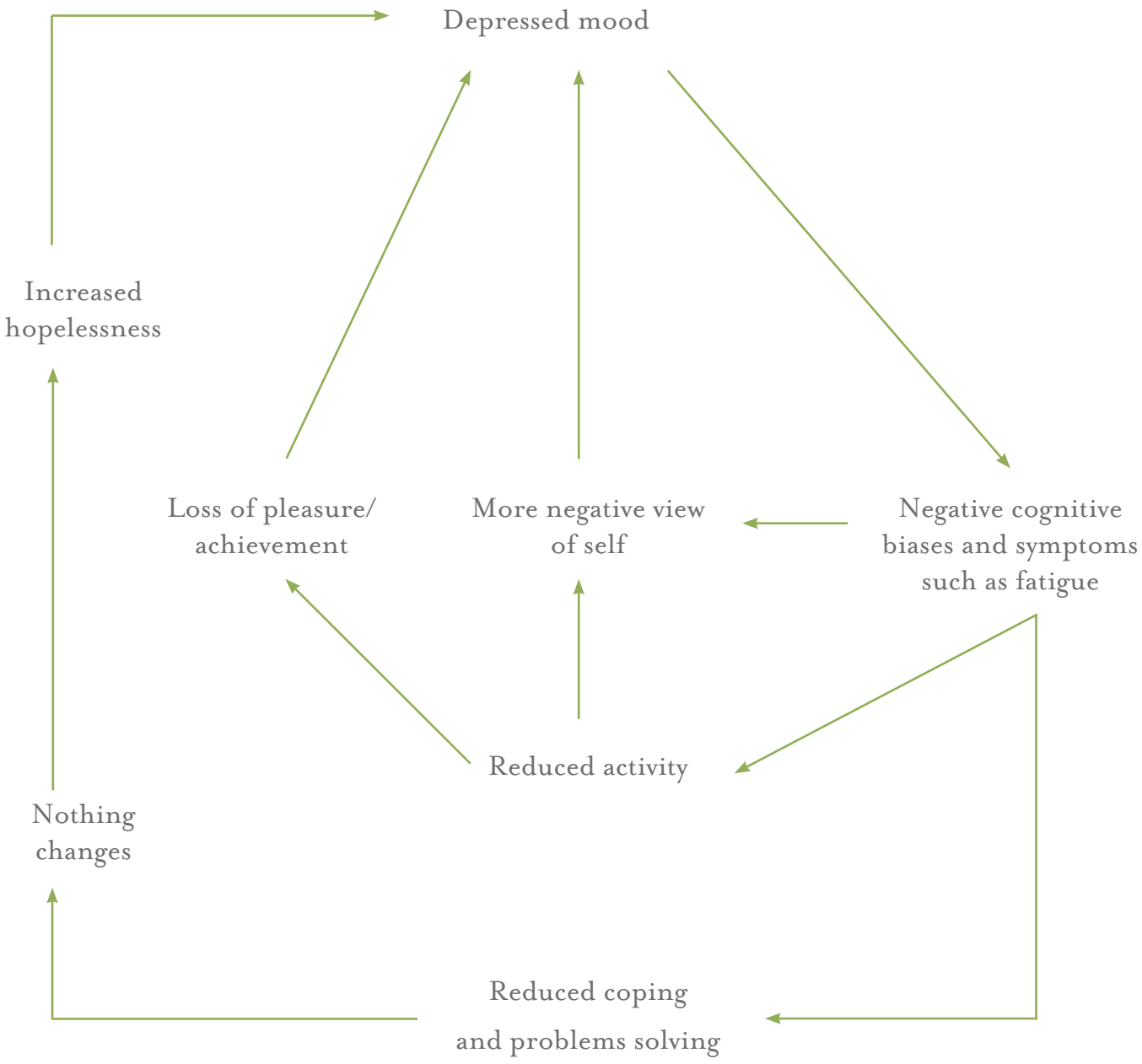
"Compassion reduces shame, frees the sufferer from the internal compulsion to conceal their vulnerability, and creates the conditions whereby they can own and reveal their experience as it unfolds" Gilbert, 2006

Beginning an activity

Activity scheduling is one of the core therapeutic techniques in CBT for depression, (Beck, Rush, Shaw ET Emery, 1979) and is based on the processes which serve to maintain depression has illustrated in the diagram below

Common Maintenance Processes in Depression

(Westbrook, Kennerley et Kirk, 2007)



COMMON PROBLEMS IN ACTIVITY SCHEDULING

Westbrook et al (2007) highlight the following difficulties that arise:

Lack of pleasure **Excessive standards** **Vague planning**

They stress the importance of realising that, in the early stages of fighting depression, clients often do not enjoy anything as much as they used to before their depression. It is therefore helpful to encourage them to persevere even though there may be **little pleasure** to begin with. Persevering itself may offer a sense of achievement before a sense of enjoyment returns. It is also important to look at the idea of pleasure as a continuum – not all or nothing- but a gradual increase of enjoyment as the depression begins to lift.

In relation to **excessive standards** the client shall need to be reassured that, what appeared easy when she felt well may seem difficult when feeling depressed and it is therefore important that any small activity needs to be acknowledged and celebrated.

When planning activities it is better to be **specific** so that the client is helped to choose one small and simple activity to do – for example making and drinking a hot cup of tea sitting down or having a bubble bath. It is a huge achievement to both think and carry out the activity and needs to be recognized both by the therapist and the client.

The Working Alliance in CBT

Beck et al (1979) recognize empathic collaboration as key to developing a working alliance between the therapist and the client. Such collaboration involves establishing a relationship that is based on trust and rapport and working together as a team. The team philosophy embraces the notion that both therapist and client bring their own expertise to the sessions and share responsibility for change.

Kennerley quotes Bordin (1979) in her chapter in the book by Whittington et Grey (2014) who itemizes the working alliance in CBT in three parts:

- Goals: what the client and therapist hope will be gained from therapy;
- Tasks: what needs to be done in therapy to achieve the goals;
- Bond: a positive therapist-patient relationship formed from trust and confidence that will support the tasks that will, in turn, bring the patient closer to his or her goals.

Forgiveness and Depression

Gilbert (2006) reflects that, if a client establishes a trusting and accepting relationship with a therapist, then the therapist may have enough 'authority' or 'influence' to offer the experience of a relationship in which the client is able to feel forgiveness, understanding and acceptance. From this relationship it is possible that a compassionate and forgiving approach to the self may grow and thus allow healing to begin.

Time for mum

Session 2

Elpitha Support Group

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SESSION TWO

"Time for mum"

Welcome back!

Review previous session.

Briefly review reactions to the material, which was covered in the previous session.

'How did you feel after last week's session? Would you like to share with us if you were able to do one thing for yourself that you used to enjoy and how that made you feel?'

Summary of last week

'Last week we met one another and began to talk about our pregnancy, birth and early parenting experiences. We also started to look at what postnatal depression is and ideas about what we will do to get on top of it.

It helps to look at having a good balance in life, so that when things are difficult, we can also focus on something positive, or something we enjoy doing. Feeling low or being depressed is a sign that this balance has been upset. Today we will look at ways of bringing this balance back.

Role Play

How we feel, is directly connected to the way we behave, and the way we think. To indicate this, we will be putting on a little show for you! Whilst you are watching us, please try to be aware of what's happening with our thoughts, feelings and behaviour.

Do this role play twice, once where a person takes a parking place out of turn and that person is mad at the driver and then a second time when she is mad until she realizes that the driver is a friend of hers (explore thoughts, feelings, behaviour) and her reaction becomes calmer and her thoughts different (again explore thoughts, feelings, behaviour)

A second role play is also done where two friends are walking either side of the street, one friends recognises the other but the other friend is unaware of their presence:

1. Person waves but believes that her friend is daydreaming and that she will catch up with her later on

2. Person waves but is annoyed and upset as she believes that her friend is ignoring her and intends not to make future contact

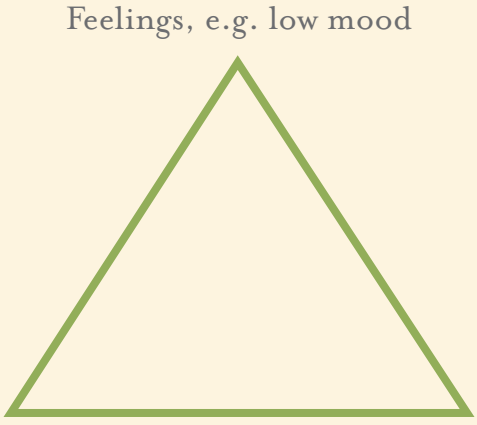
3. Person waves but is concerned that her friend looks worried and deep in thought and plans to ring her later on to see if she is okay

This is to demonstrate that 3 identical scenarios result in quite different interpretations and outcomes. For feedback and discussion. Relate to thoughts, feelings and behaviour again.

Use handout 5 to explain how depressive feelings arise from events associated with unpleasant outcomes. Depressive feelings can also result from putting ourselves down and being self critical, as well as negative interpretations of situations we find ourselves in. Use examples and ask the mothers if they are able to think of any situations themselves that have happened to them.

HANDOUT 5

The relationship between behaviour, thoughts and feelings



Behaviour, thoughts and feelings all influence each other.

BEHAVIOUR, THOUGHTS AND FEELINGS ALL INFLUENCE EACH OTHER

Relationship between feelings and behaviour.

Demonstrate in more detail the functional relationship between behaviours and mood by introducing the concept of a downward spiral into depression. Explain the depressive spiral to the mothers using handout 6. Use examples from the mothers' experiences to illustrate the concept.

One mother described her depression as like being in a dark hole where the ladder has been taken away. The depressive spiral is a way of explaining how we can end up in that dark hole. We would like to look at putting the ladder back, to help you climb out of that black hole.

Being aware is our first step forward, aware of what begins us on our downward spiral so that we can help to prevent ourselves from tumbling further into the black hole.

SESSION TWO

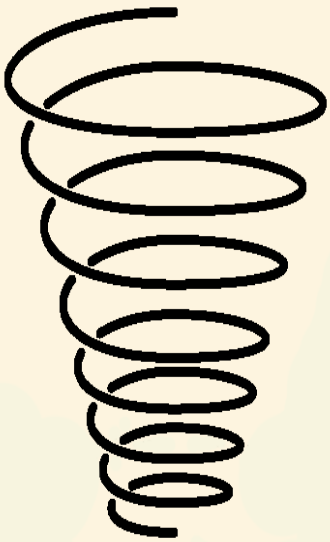
HANDOUT 6

The depressive spiral

Feel depressed.

Feel more depressed.

Feel even more depressed.



Engage in few activities with happy outcomes.

Not wanting to go out and mix with family or friends

Do even less for ourselves or with others.

After discussing this spiral of feeling, and certainly from experience, we know that withdrawing/isolating ourselves from the outside world, can lead to a worsening of feeling low, and make it more difficult to get help

Satisfaction and happiness are feelings we experience when we are engaged in pleasant activities with positive outcomes. (Link in with past homework)

As we know that people who suffer from depression block out positive events (and often focus on negative events), it is important that you draw attention to everyday events that have positive outcomes.

- Depression is often experienced when negative activities outweigh the numbers of pleasant activities we do every day.

  Pleasant activities play an important role in relation to mood. If the number of pleasant activities falls below a critical level, your mood is likely to become increasingly depressed.

Ask if they are able to think of one moment that was able to lift their mood temporarily (one may self-share here if needed e.g. heard music/song one likes)

BREAK

Pleasant activities and mood

The activities that occur during a typical day can be thought of as two main types. Type A activities are either neutral or unpleasant. They are obligatory activities that we may not enjoy e.g. washing the dishes. Type B activities are the activities that we really enjoy. They are the activities we would choose to do whether obligatory or not, e.g. lying in the warm sunshine talking to a friend. A suggested trigger to remember type A is "awfuls" and for type B "beautifuls".

Group discussion

Group discussion about this activity can be facilitated with the following types of questions:

'What sort of balance do you have between A's and B's?' 'What relationships do you think there is between "awfuls" (type A) and "beautifuls" (type B) activities and your mood?'

'Are there too many type A activities on one day? If so, is it necessary to do all these activities in one day? Could you transfer any of these type A activities to another day?'

'Are there any activities that seem to have a strong impact on your mood? For example, for many mothers, social interaction is a potent type B activity and they notice that, when they are at home alone with a baby all day, their mood is lower because they feel isolated.'

Awful and Beautiful Chart

Following on from this, shall we have a look at activities that may help us feel a little better? Lets talk about these first, by each sharing an activity that we have enjoyed in the past.

HANDOUT 7

Activities that help to improve our moods

Pleasant social interactions

e.g. honest and open conversation with a friend, cuddles with baby or a warm bath

Experiences that make us feel competent

e.g. learning to do something new; being able to settle our own baby when no one else has been able to.

Activities that work against feeling depressed

e.g. sleeping well; laughing; being relaxed.

Difficulties

'One of the difficulties that we all may be experiencing at the moment is finding enough time to look after ourselves. You have all done very well to manage to find the two hours today and to get here. You are probably wondering how you are going to fit more pleasant activities into your week.

Some problems with pleasant activities that can happen are due to:

1. Pressure from activities that we consider not to be pleasant but which must be performed.
2. Poor choice of activity e.g., staying at home rather than going to a friends house.
3. Something happens to remove the availability of a pleasant event (e.g., the demands of a baby may prevent you from going out with friends as often as you did before).
4. Anxiety and discomfort interfering with enjoyment (e.g., being anxious about always doing the right thing).
5. Critical thinking that 'we do not deserve to be happy or to have time for ourselves'. If our thoughts are like this, try to think what we would say to a close friend in a similar situation whom we would be kind and compassionate with. We then try and do this with ourselves and to be a friend to ourself.

Have a look at handout 8 and, before we meet next week, we would like you to try and do one of these activities. If you would like to add your own to the list please do.

HANDOUT 8

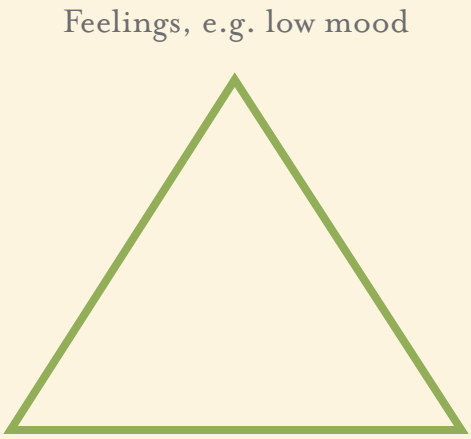
Pleasant activity ideas

1. Being in the Country
2. Meeting someone new of the same sex
3. Planning trips or vacations
4. Reading stories, novels,non-fiction poems, or plays
5. Driving skilfully
6. Breathing clean air
7. Saying something clearly
8. Laughing
9. Being with animals
10. Have a frank and open conversation
11. Going to a party
12. Playing a musical instrument
13. Wearing informal clothing
14. Being with friends
15. Making food or crafts to sell or give away
16. Gardening, landscaping, or doing yard work
17. Wearing new clothes
18. Sitting in the sun
19. Going to a fair, carnival, circus, zoo or amusement park
20. Planning or organising something
21. Having a lively talk
22. Having friends come to visit
23. Getting massages or back rubs
24. Getting letters, cards, or notes
25. Going on outings (to the park, a picnic a barbecue, etc.)
26. Talking about my children
27. Seeing beautiful scenery
28. Eating good meals
29. Going to a museum or exhibit
30. Doing a job well
31. Having spare time
32. Going to a health club, sauna bath, etc
33. Learning to do something new
34. Being with my parents
35. Talking on the telephone
36. Kicking leaves, sand, pebbles, etc
37. Going to the movies
38. Kissing
39. Being praised by people I admire
40. Washing my hair
41. Going to a restaurant
42. Being invited out
43. Reminiscing, talking about old times
44. Writing in a diary
45. Reading the newspaper
46. Doing housework or laundry; cleaning things
47. Listening to music
48. Being with someone I love
49. Shopping
50. Watching people
51. Being with happy people
52. Having people show interest in what I have said
53. Expressing my love to someone
54. Having coffee, tea, a coke etc, with friends
55. Being complimented or told I have done well
56. Being told I am loved
57. Seeing old friends
58. Other ideas.....

SESSION TWO

HANDOUT 5

The relationship between behaviour, thoughts and feelings



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SESSION TWO

HANDOUT 6

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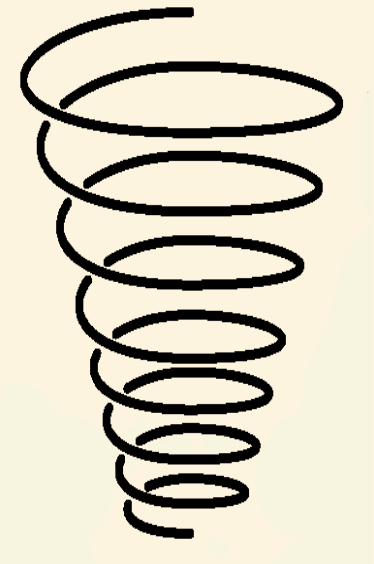

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SESSION TWO

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SESSION TWO

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SESSION 2: TIME FOR MOM:

SUPPLEMENTARY BACKGROUND INFORMATION

The Biopsychosocial Model of Postnatal Depression

Milgrom, Martin et Negri (2006) state that, although some researchers believe that hormonal and endocrine changes in the postnatal period might contribute to depression in women following childbirth, many professionals consider that biological explanations are only part of the story.

"The other part of the story is that the transition to motherhood involves adapting to huge physical, emotional and social changes. While some cultures have structures in place that are supportive of new parents, in our society many mothers are given little preparation for, or support in, their new roles.

It is not surprising, then, that many mothers have difficulty adjusting and that they feel, at times, overwhelmed by the demands and expectations of motherhood.

The mythologies in our culture about the "joys" of pregnancy and of "perfect" motherhood also have a powerful influence on us, often creating unrealistic expectations about pregnancy, birth and motherhood. Mothers who hold these expectations and beliefs often feel like "failures" when they experience problems coping, and depression is a common outcome.

Depression, after childbirth, affects 10 – 20% of women."

(Milgrom et al, 2006 p. 79)

Using imagery and role play

The use of experiential strategies such as imagery and role play can be invaluable in shifting unhelpful cognitions (thoughts). (Westbrook et al, 2007)

As role play takes place in group sessions, it is only carried out by the facilitators and offers an important insight to those attending, by witnessing both negative and compassionate interpretations of events. The group members, in this way, realise how our way of thinking affects our mind and our actions but is neither about what is happening at the present moment nor who we actually are as **thoughts are only thoughts not facts.**

The above may be linked to the "Awful and Beautiful" discussion as there is always a difference in opinion as to whether a certain activity is looked upon as 'awful' or 'beautiful', for example cooking a meal.

Interpretation of Events

Role Play 1:

Milgrom et al (2006) provides a good living example of the above in the following scenario:

"Our feelings (our mood and emotional states) are directly connected to the way we behave and also to the way we think. For example, if someone rushes to get into a car park space that was rightly yours at the supermarket, you may think 'That selfish person. How dare she push in? That's not fair'.

You may feel angry as a result of your thoughts about the unfair nature of the world. However, if the person who gets out of the car is a friend of yours and was having a joke with you, you may think 'Oh, typical …. She's just trying to be funny and it's actually really nice to see her'. As a result of your new thoughts, you may feel calm and happy. You may even laugh.

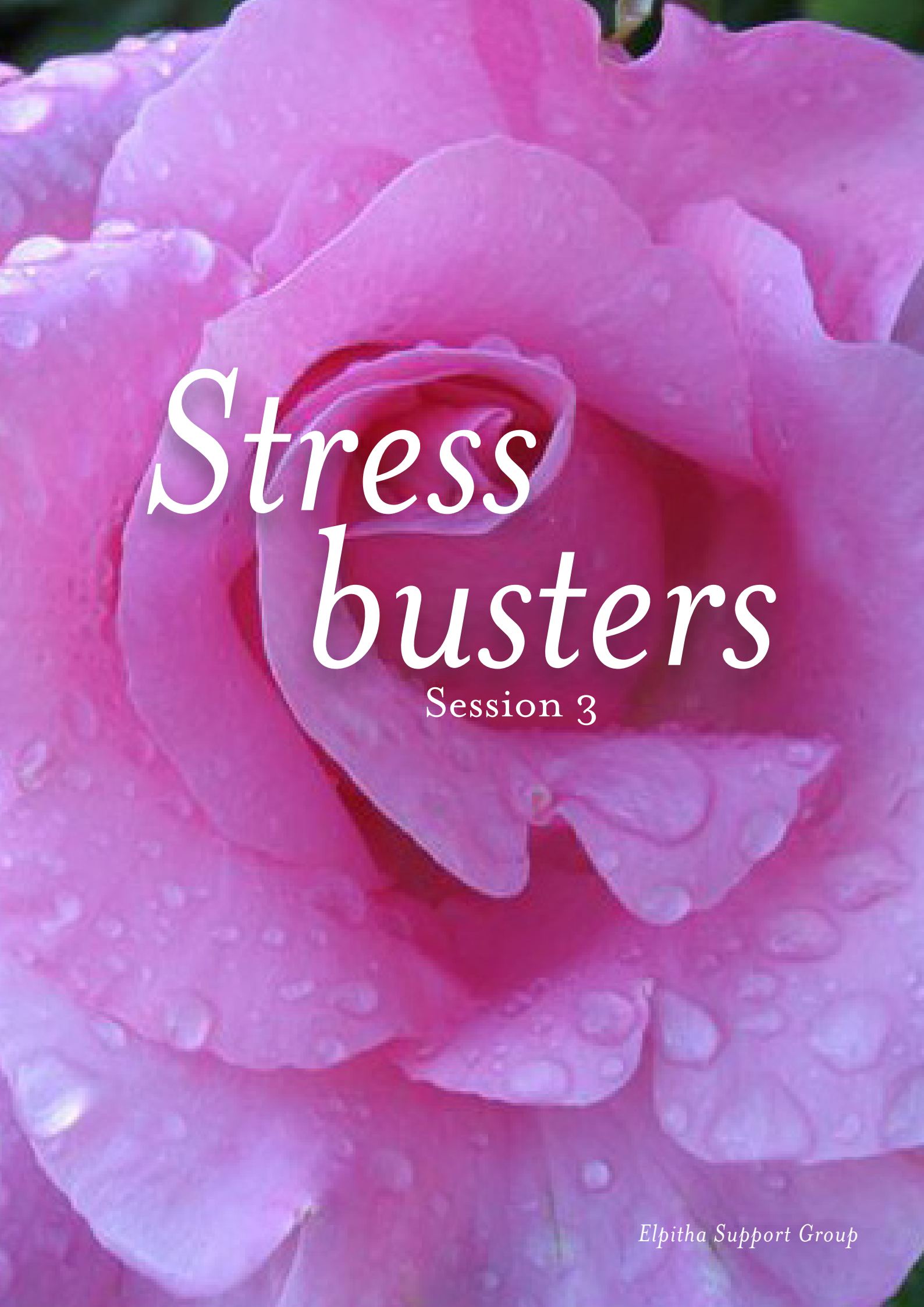
In the same way, our behaviour can sometimes affect the way we feel. For example, if you stay at home because 'it's easier', you may start to resent the fact that you cannot get out of the house and start to feel lonely, isolated and depressed.

"Research and clinical experience have shown us that successful treatment of postnatal depression requires a multi-pronged approach that equips women with the skills to make positive changes in a range of different areas of their lives." (Milgram et al, p. 85-86)

Role Play 2:

This role play is taken from the writings of Segal, Williams and Teasdale (2002) where one person is walking down the street and, on the other side of the street, she sees a friend. She smiles and waves but the person just doesn't seem to notice her and walks on by.

This is done three times to demonstrate three types of feelings (feeling both angry and upset; feeling concerned and worried; feeling amused) and the subsequent behaviour and thoughts that go along with these feelings. It is a powerful demonstration of how the same scenario may result in three very different outcomes according to our interpretation of events depending on our mood state.



Stress busters

Session 3

Elpitha Support Group

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SESSION THREE "STRESS BUSTERS"

Feedback – Following on from last week, what pleasant activity were you able to do? What were your thoughts and experiences? Did you notice how you felt just before the activity and how you felt afterwards? What did you find? (Use of flip chart)

We are now going to have a look at things, which cause us stress in our lives, is any one able to start by giving us an example? (Use of flip chart)

The following are what other mothers have said causes them a lot of worry:

Looking at high stress times

HANDOUT 9

High stress times

- 5-7p.m. dinner time
- Getting ready to go out
- Getting baby to sleep
- When baby or child is sick/crying
- Other people interfering with baby's routine/criticising me
- Tantrums in the supermarket
- Long trips in the car with a screaming baby
- Tensions with a partner or an absent partner
- Other examples .....

'A common time that is difficult for mothers is around dinner time. Just when you need to prepare and serve dinner, the baby launches into crying inconsolably and wants to be held and attended to more than at any other time of the day. This is perfectly normal, although extremely stressful.'

HANDOUT 10

Recognising early warnings signs of tension

- Shakes
- Back pain
- Slamming doors
- Raised voice, sarcasm
- Rejection of help
- Clenched jaw, palpitations
- Holding breath
- Noises seem louder
- Distressed thoughts, e.g. *'I can't stand this', 'I'm not coping', 'I should stop this now'*
- Muddled mind
- Loss of confidence
- Indecision
- Overwhelmed

Be sure that mothers identify their own cues of anxiety, including bodily sensations. Also explore thoughts during the times of high tension.

WE BECOME SO USED TO FEELING TENSE THAT WE FORGET WHAT IT IS LIKE TO BE RELAXED.

Coping with tension

High tension Situation/*body* cues	How I coped

Can you see anyway you could have nipped the stress in the bud?

BREAK

Relaxation

Different forms of relaxation.

Today we are going to look at relaxation training.

'Anxiety and tension get in the way of overcoming our depression because tension interferes with enjoying things. It is an obstacle to getting the most out of the pleasant activities that we are slowly building back into our lives. Tension causes tiredness, irritability and often physical problems like headaches. It is another behaviour that we can try and change, which will impact on our mood.

Of course, a certain level of anxiety, tension and drive is necessary in order to motivate us to carry out our daily tasks and responsibilities. However, it is when this level of anxiety and tension gets too high that it interferes with our ability to cope.

What kind of things can help us relax?

Ask mothers if they have had experience with relaxation before. If it was not a good experience you may need to talk about the range of different techniques they may try until they find a technique that they are comfortable with.

Think of all our senses – eyes (candle, sunset, sky), ears (music), touch (massage), breath (slowly and gently), smell (aromatherapy), speech (repetition of certain calming words).

For example, with music, here is a quote to help show how much it may help:

"Songs you know by heart
Songs that stir the soul
That stick in your head all day
And are welcome there
Its not just what the music says
But how it feels, the colour of a song
Its shape, the way it can define a time,
A relationship, a memory
A visual soundtrack to those moments
And emotions that mean the most to us"

However it is important to remember the good feelings that may come from such memories but to try and resist the temptation to wish for the past to return. In this way we begin to learn to live in the present moment with periods of feeling better inside.

Today we will teach you a technique for learning to relax. People are different with regard to how quickly they can learn to relax. Relaxation is a skill that requires repetition and will improve over time (with practice!).'

Relaxation skills are particularly useful when they can be used before or during a stressful activity or part of the day. Let us try one of them when we relax the muscles of our body and focus on our breathing.

GROUP DISCUSSION

Ask mothers the different ways they think would help them relax with the use of the flipchart.

HANDOUT 11

Portable stress busters

- Have a shower, bath
- Deep breathing, focusing attention on breath rather than on thoughts
- Yoga techniques
- Ring a friend, family member or person you trust
- Self statements:

  'I am calm and relaxed'

  'I can do this'

  'This will pass'
- Treat yourself to coffee, wine, chocolate cake (but not in excess!)
- Mini 'mental holiday' – think of favourite holiday destination
- Releasing tension in muscles/listening to music
- Three deep breaths
- Reminding myself *'I'm not alone'* (as a mum)
- Crying as a release
- Comparing self with others in a worse position

Homework:

To try and practise one of the relaxation techniques learnt (discuss and revisit)

SESSION THREE

HANDOUT 9

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SESSION THREE

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SESSION THREE

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SESSION THREE:

STRESSBUSTERS: SUPPLEMENTARY BACKGROUND INFORMATION

This session recognises the stress we hold within us and involves practising basis relaxation techniques.

Body Scan

The relaxation exercise involves asking the Mothers to sit comfortably in their chair with their feet on the floor and then to tense and relax the muscles of the body beginning at the feet and then progressing upwards to include the calves – thighs – buttocks - stomach – shoulders – arms – hands – face, slowly moving from one part of the body to the next. Participants may have their eyes open or closed as some Mothers are nervous of this exercise and may never have experienced sitting quietly or relaxation before. This exercise is known as a 'body scan' where, by becoming more aware of the body's messages, the thoughts become less busy as they have a focus to concentrate on.

Sitting with the Breath

The session then moves to a form of meditation in which the attention is kept on a single focus, being the breathing, for approximately 3 to 5 minutes. The Mother is asked to think about her breathing slowly moving in and out of her body (e.g. through her nostrils, chest rising). Some members might like to think that they are breathing in calmness and breathing out stress.

The Mothers are reassured during this exercise that it natural for their thoughts to keep drifting but are asked to look upon the thoughts as an observer watching a train pass through a railway station 'ah there is another thought' but then to bring the thoughts back to the breathing. In this way the Mother does not become swept away in another trail of thoughts with emotions attached to them. Identifying negative judgmental thoughts as recurring mental patterns can be of enormous help in allowing the Mother to relate to them more objectively and less personally and to slowly realize that they are not reflections of truth or reality but of being depressed (Williams, Teasdale, Segal, Kabat-Zinn, 2007). The exercise provides real experience of being able to control, if only for a short while, their thought patterns and to focus their thoughts on an object of their choice.

Segal, Williams and Teasdale (2002) use this 'sitting with the breath' in their Stress Reduction Clinic in order to introduce the idea that, in order to be able to deal with old mental habits, we need first to become aware of them and have a way to release ourselves from their grip. They state that it is just as valuable to become aware of when the mind has wandered away from the focus of breathing and to bring it back, as it is for the mind to remain fixed on the breathing. They consider that this is an important part of learning how to pay attention in this new way: on purpose, in each moment, and without judgment.

Being firm but kind

Session 4

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SESSION FOUR
BEING FIRM BUT KIND

Assertiveness and self esteem

(being able to say how I feel and what I think in a firm but respectful way)

Assertiveness skills

'Many activities which impact on our mood involve social interactions with other people. Social skilfulness is the ability to interact with other people in such a way that the experience is a positive one. There is no right way. We all have a slightly different style of obtaining positive responses from others. For example, one person may complain about her hairstyle in order to receive positive comments from others that she looks great. Another person, on the other hand, may compliment someone on their hairstyle and receive a positive response in reply. The outcome for both women is positive but they have elicited that positive outcome in different ways.

We have decided to focus specifically on assertiveness skills relevant to motherhood which often places us in situations that we have never been in before. For example, no one has ever told you how to behave on a bus until you have a baby with you. Suddenly someone tells you that your baby is hungry and that you should feed it. Assertiveness is the ability to express your thoughts and feelings openly (eg, complaints and affections). We believe assertiveness is particularly relevant to new mothers for a number of reasons.'

'Everyone, it seems, has had some contact with babies and children at some stage in their life and many are too willing to give you advice about how you should be doing things, or worse, how you should be feeling. Being able to express your thoughts and feelings openly will mean that you will be better able to request assistance you would like and decline advice/assistance when it is not asked for.'

WE ARE GOING TO DO THREE ROLE PLAYS. They are divided up into three responses, one will be a passive one, the second an aggressive one and the last an assertive response. We would like you to watch and tell us what you think about them at the end. Look at our actions and how we meet each situation and if you could see how it could have been handled differently.

BE AWARE OF OUR POSTURE, TONE OF VOICE, CONTENT, EYE CONTACT, AND POSITIVE REGARD FOR SELF AND OTHERS. (WRITE ON FLIP CHART: PASSIVE - AGGRESSIVE - ASSERTIVE - PLUS BODY LANGUAGE ABOVE)

These situations may appear a bit funny here but we know if they happen at home or outside they can be very difficult to deal with.

FIRST SCENARIO: Interfering aunt visits mother and child at home and insists on giving the child sweets although mother tries to tell her that her child is sensitive to the colourings and additives and will be hyperactive as a result.

SECOND SCENARIO: Mother with baby crying on the bus and another person who is sitting on the seat behind her telling her that the baby is hungry.

THIRD SCENARIO: Mother has been asked to seek help from the doctor by a close friend who thinks she is suffering from depression. Interview with the doctor.

FEEDBACK USING THE FLIP BOARD

(Passive/Aggressive/Assertive Styles)

Warm Relationships

'Assertiveness and open communication can facilitate the development of close, warm relationships. Other people are able to understand your feelings and needs better if you are able to communicate them in an assertive way.'

Prevention of Conflict

'Assertiveness can help to prevent conflict. Aggression is usually met with aggression, and if a concern is not expressed it is generally ignored. Assertiveness allows the thoughts and feelings of everyone involved to be expressed and respected.'

Handout 12 below describes communication styles

Communication styles

	PASSIVE	ASSERTIVE	INDIRECT	AGGRESSIVE
Basic attitude	I'm not okay	I'm okay and you're okay	You're not okay but I'll let you think you are	You're not okay
Philosophy	Take care of others' rights and needs without regardto one's own	Take care of own and others' rights and needs	Take care of own rights and needs while letting others think you care about their rights/needs	Own rights and needs are met at the expense of others
Behaviour	Retreating Giving up Resenting situation	Confrontation Honesty Negotiation	Manipulating Sarcasm	Nasty comments Put-downs Screaming
Response from Others	Attention Sympathy	Respect Acceptance Comfort	Suspicion Confusion Feels manipulated	Fear Hurt Humiliation Defensiveness Aggression

Guide mothers through the handout.

It is important to inform mothers that although assertiveness usually leads to more positive outcomes, **there are a number of factors that may prevent us being assertive all the time.**

Tiredness or high anxiety may impact on our ability to be assertive, *especially if this does not come naturally. At these times we may slip into our more usual way of interacting with others. It is also true that everyone alternates between the different forms of communication style depending on the situation at hand. An assertive person will not always be assertive as it is important to consider the cost of being passive or aggressive in a given situation. If you are aggressive in a shop because your order is not ready on time, you are able to choose whether to go to that particular store again. If you are aggressive with a member of your family when he/she is on their way out in the morning, the cost when the family member returns at night will be high and it is not simple to choose never to speak to them again! The same is true with being passive. It is of relatively little importance if the shop serves someone before you; however, it is a major problem if your family continually disregards your views, feelings and rights because you are not assertive. In other words, having the skills to be assertive does not mean you will always choose to use them. It is ok to be passive if that is a* **conscious choice.**

Self esteem

'Being assertive has a lot to do with how you feel about yourself (your self esteem). You are not likely to ask for what you need or to tell others how you feel if you don't think you're worth it.

Self esteem is the value you attach to your own identity. It is your prediction of how successful what you do or say is going to be, even before you have acted. Lowered self esteem and feelings of worthlessness are part of the experience of depression. Often, people who suffer from depression do not act assertively or do few activities that will improve their mood (eg., telephone a friend). Part of the reason is that they are convinced that the behaviour will not be good enough or they are not worth it (eg., 'I can't even have dinner cooked on time' or I don't deserve to go out .')

Self esteem is developed from our very first social interactions as a baby through to current experiences. Although it is very difficult to change the value that you now place on your self-worth, one way to start to improve your self esteem is to notice the skills/talents/attributes that you do value about yourself. Remind yourself frequently about these.

Sometimes self esteem and feelings of worthlessness are further lowered by the experience of depression, and women forget the more positive view of themselves that they had when they were not depressed.

Ask each one to name a positive quality they have (may be friendly, sense of humour, kind). Start with yourself and, if someone struggles, help them out e.g. 'I think you are a kind person'.

Homework

Try and use the Assertion Monitoring Form (handout 13), to make a list of any difficult situations you have dealt with or would like to deal with in an assertive way.

SESSION FOUR

HANDOUT 12

Communication styles

	PASSIVE	ASSERTIVE	INDIRECT	AGGRESSIVE
Basic attitude	I'm not okay	I'm okay and you're okay	You're not okay but I'll let you think you are	You're not okay
Philosophy	Take care of others' rights and needs without regardto one's own	Take care of own and others' rights and needs	Take care of own rights and needs while letting others think you care about their rights/needs	Own rights and needs are met at the expense of others
Behaviour	Retreating Giving up Resenting situation	Confrontation Honesty Negotiation	Manipulating Sarcasm	Nasty comments Put-downs Screaming
Response from Others	Attention Sympathy	Respect Acceptance Comfort	Suspicion Confusion Feels manipulated	Fear Hurt Humiliation Defensiveness Aggression

SESSION FOUR

HANDOUT 13

Assertion Monitoring Form (0 – 10 assertive)

Situation	Asserting myself 0 – 10
1.	
2.	
3.	
4.	
5.	

SESSION FOUR

BEING FIRM BUT KIND: SUPPLEMENTARY BACKGROUND INFORMATION

In this session role play is used to demonstrate assertiveness, aggression and passiveness using everyday examples from motherhood.

Gilbert (2009) recognises that, in depression, anger is often related to hurt, vulnerability or feeling blocked as is feeling submissive. He sees assertiveness as a compassionate way to deal with these feelings.

Below is a table offering details on non-assertive, aggressive and assertive forms of behaviour, feelings and thoughts (Gilbert, 2009, p. 474)

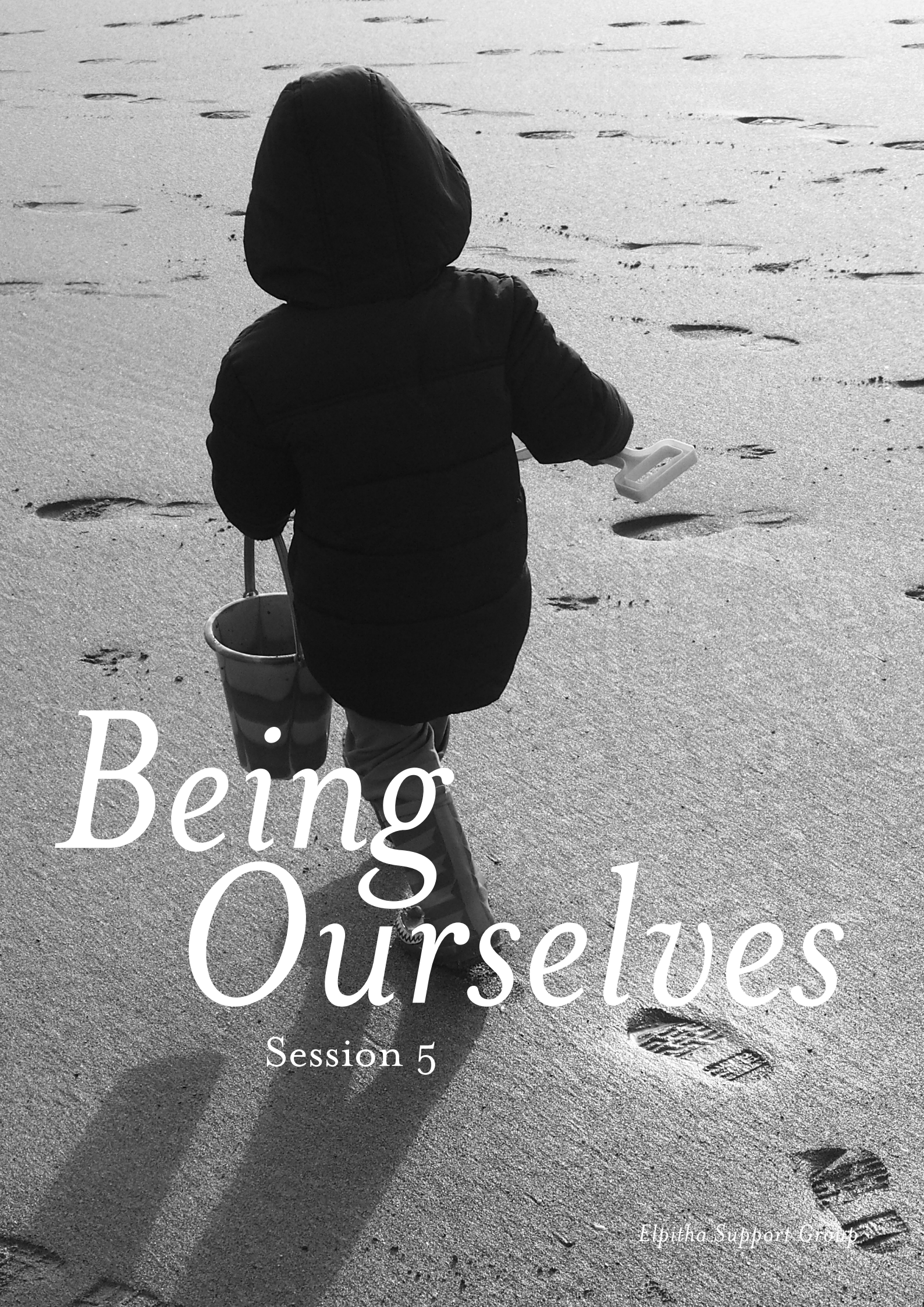
NON-ASSERTIVE	AGGRESSIVE	ASSERTIVE
BEHAVIOUR		
Looks down or backs away	Stares and 'looks' angry, threatening	Meets eye contact but avoids 'the angry face'
Tries to signal 'no threat'	Wants to signal threat - to be obeyed	Wants to signal 'listen to my point of view'
Allows other to choose self	Chooses for (and imposes on) self and others	Tries to reach agreement
FEELINGS		
Is fearful of the other	Is angry or enraged with the other.	Tries to control both anger and fear
Hurt, defeated	Feels a victim and sense of injustice	Recognizes that one can't have everything one wants

NON-ASSERTIVE THOUGHTS	AGGRESSIVE	ASSERTIVE
My view is not important	My view is the most important	All views have a right to be heard
I don't deserve to have this need, want or desire	My wants and needs are more important than other people's	Each person's needs and wants are important
I will lose	I will (or must) win	It is preferable for no-one to win or lose but to work out how to give space to each person
I am inadequate or bad	I am good and in the right	Right and wrong is all-or-nothing thinking and labelling. It is preferable to work out what the issues are rather than labelling or attacking the person or oneself
Just here to please others	Others should do as I want	We should try and please each other in a mutually sharing and caring way
Self-attacking	Other-attacking	Avoids attacking

A helpful phrase to offer self-critical Mothers learning to be more assertive is as follows:

"If a friend had been in a similar situation, I would not have attacked her in the same way that I attack myself – for I know that this would have made her feel much worse."

(Gilbert, 2009)



Being Ourselves

Session 5

Elpitha Support Group

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SESSION 5
BEING OURSELVES

Feedback from last session.

Welcome back. Last week we looked at assertion and being assertive in certain situations and how this may help us feel better about ourselves and raise our self esteem.

Review of Communication Styles (handout 12) and

Assertion Monitoring Form (handout 13) Ask if any of them have examples they would like to share.

We are now going to look at someone, who perhaps we can all identify with, who is very critical of herself.

HANDOUT 14

Being kind to ourselves

'I know that having high goals helps me to do my best but the fact that I am sometimes disappointed enough to feel very depressed may show that I am aiming too high. Maybe instead of always comparing my goals to other mothers', I could just notice the things that I have done and see this as an achievement.

What do you think, is there anyway we could look at what we have achieved other than what we haven't achieved, for example, what have we all achieved this morning?

USE OF FLIPCHART

We need just to focus on small positive things we may have done, e.g. getting up, feeding our child.

Discuss the use of a **SURVIVAL BUCKET**

Feelings to prompt using it

What to put in the bucket

Actually take a bucket (or waste paper bin with a smiley face on) and ask each member to write down what helps them to get through difficult situations. (This may be 'breath', 'go for a walk' etc.). Hand out small pieces of paper with pens. The completed notes are then folded and placed in the bucket following which each member will then take out a note written by another group member and read it out. These are written on the flip chart and always promote some laughter and discussion. The ideas are then typed up to be distributed at the next session as 'Our Survival Bucket'

Discuss with them about making their own 'personal bucket or box' at home containing happy photos, cards or uplifting words which may be looked at to help promote positive feelings

BREAK

'Our positives'

Give a small notebook plus pen to each mother with their first name nicely written on the front. The book for the specific person should then be handed to the one sitting on her left. This is to ensure that, as each member writes in the book about the positive things she feels about the named person, all members of the group will have written in the book as it is passed to the left in a clockwise direction, finally ending up with the named person.

This is called a 'positive data log', some may wish to call it 'my book' or any other name but it makes sure that each person in the group ends up with their own personal book containing positive comments from the other group members present. This is quite powerful as some members have rarely had positive comments said about them. It is a book that may prove to be a source of comfort and encouragement when they may be feeling low in the future.

Inbetween activities: for the mothers to write one positive thing in their book each day and to think of a few words they could write on a small card ('flashcard') to carry with them (e.g. in their purse), in order to help them in times of stress or feeling low.

SESSION 5

HANDOUT 14

Being kind to ourselves

'I know that having high goals helps me to do my best but the fact that I am sometimes disappointed enough to feel very depressed may show that I am aiming too high. Maybe instead of always comparing my goals to other mothers', I could just notice the things that I have done and see this as an achievement.

SESSION 5: BEING OURSELVES: SUPPLEMENTARY BACKGROUND INFORMATION

Survival Bucket

The purpose of the survival bucket is:

To respect each individual contribution

To learn from each other using a relaxed fun approach

To accept each other's ideas in a non-judgemental way

To provide tools to use in times of stress or crisis

It is at this stage that members of the group will not only look to the tools and strategies learnt during the course sessions but also to their own unique ways for coping with stress and depression. The results are always a mixture of new ideas, some funny, some serious, some thought provoking in addition to extracts from the course material. All these ideas are typed up between sessions and given out to the course members at session 6 in order that they may keep them in their own personal 'survival box' at home.

'Our Positives' Positive Data Log (PDL)

Negative self-beliefs and assumptions may develop from repeated negative socialisation experiences and can be shaped throughout life. It is for this reason that the positive data log is used, to gently challenge these negative self-beliefs. Normally the PDL requires that the client keeps a note of positive daily experiences in order to counteract selective attention to negative experiences (Tarrier et al, 2008).

However the group session has adapted this strategy to enable each member of the group to write a positive comment in a personal book provided for each Mother. The book is passed around each group member in session (which is always a quiet and moving session as each individual thinks about a good thing they wish to write about another member of the group). The facilitators also have a book in order to provide equanimity in the group. Each book is then taken home to be read in private, often causing tears at the kind comments that have been written. This simple task has enormous and powerful benefits:

The Mother may refer to it when she is in fear of a relapse

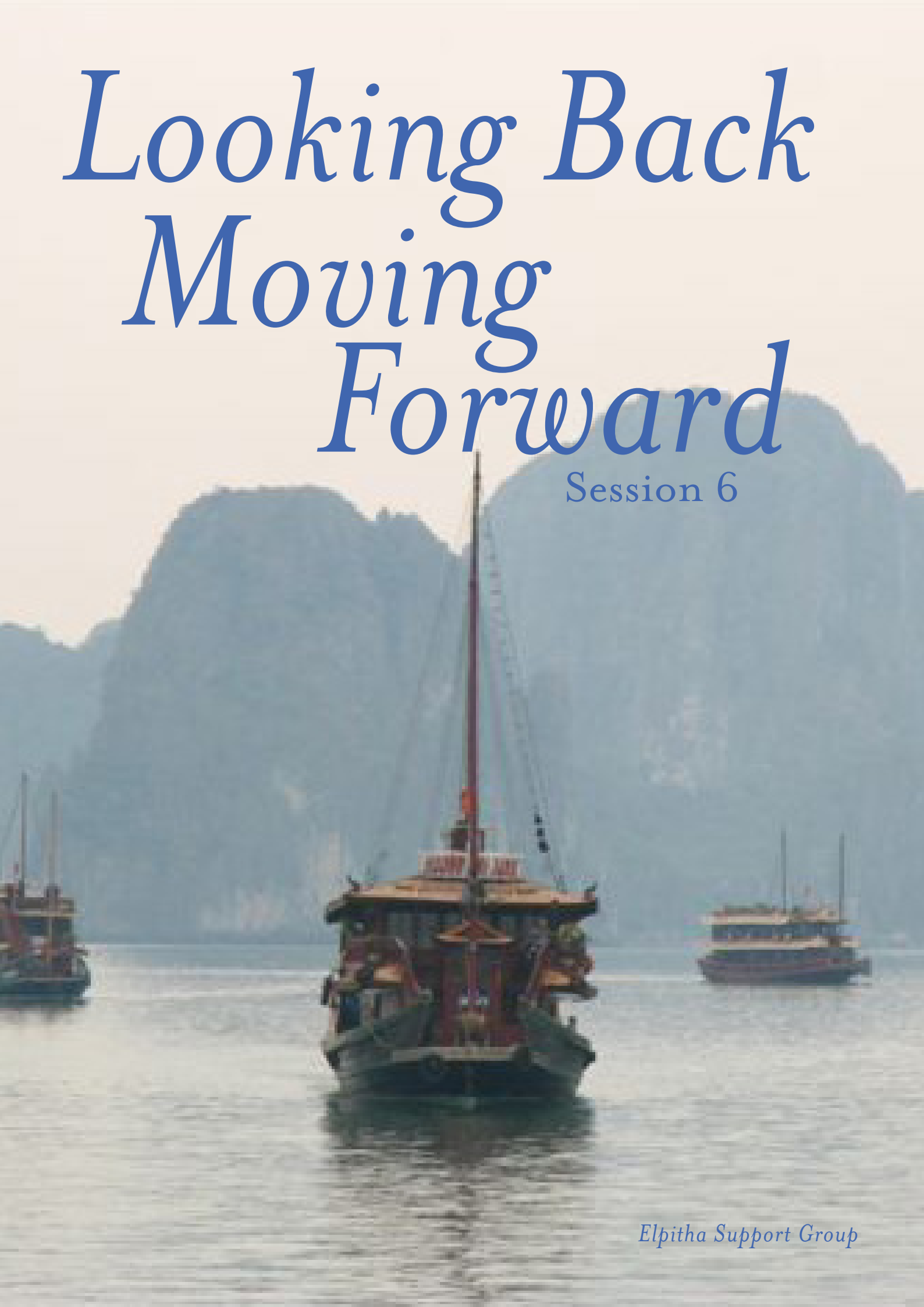
It may be the only collection of kind and positive words that she has ever received

It counteracts any negative or self-critical thoughts

It offers a 'Johari Window' view where we become aware of aspects of ourselves that others see but that we are unaware of (http://en.wikipedia.org)

Looking Back Moving Forward

Session 6



Elpitha Support Group

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SESSION 6
LOOKING BACK, MOVING FORWARD

Feedback on their 'Positive book' or whichever word they may like to call it plus to ask for suggestions for 'flashcards' to help them in times of stress (**use of flipchart**).

Overview of previous sessions, revisit important points, ask if anything stands out from the sessions

Hand outs to be filled in before break. Express how much we appreciate their feedback which helps us continue to improve the sessions and also to help us to raise funds to keep the group going. Ask the members to go and have a hot drink once they have finished in order to maintain a quiet atmosphere for the evaluations to be completed in.

End of course Evaluation Form containing open questions (anonymous)

PHQ9 (Patient Health Questionnaire) for assessing depression plus the GAD7 (General Anxiety Disorder) questionnaire to assess anxiety and panic attacks with members names, in order to make a comparison with the ones which were completed at the pre group home visit.

BREAK

Preparation for moving forward

At this stage, most mothers will have become quite attached to the group so it is important to talk about any concerns they may have about it finishing and explain that it is normal to feel worried and/or sad about the group coming to an end. You may then help them to see the experience in a positive way and instead of feeling like a loss it may be seen as a 'stepping stone' to meeting new people or doing new activities.

The following handouts will be discussed as an addition to their 'survival bucket':

Ideas to help lift low mood (refer Handout 15)

Eat to beat your the Blues (refer Handout 16)

Useful contacts (refer Handout 17)

A member of Home-Start will follow on by talking about the support of their 'family group' following the completion of the Elpitha.

To give out gifts and an attendance certificate

HANDOUT 15

Ideas to help lift low moods

- Increase your omega-3 fats. Take fatty-acid supplements and eat more cold-water fish and seafood (J Affect Disord, 2002; 69: 15-29). Low fatty acid levels just after birth are linked to postnatal depression (PND) (Life Sci, 2003; 73: 3181 – 7).

- Take yourself and your baby to a baby-massage class. As mothers with PND may have problems with relating to baby, this may help parents to better understand their babies communication signals.

- Exercise regularly. When half of a group of people hospitalised for depression did one hour of aerobic exercise three times a week for nine weeks, their depression scores were significantly lower than the group who did not exercise (Br Med J, 1985; 291: 109).

- Talk to a trained therapist or counsellor. An Oxford study showed that six sessions with a qualified therapist or counsellor was just as helpful and much safer that a powerful drug (BMJ, February 18, 1995).

- See your doctor in case you are suffering from anemia or thyroid problems.

SESSION 6

HANDOUT 16

Eat to beat your blues!

Here are some foods to give you a boost – and don't forget to **drink water** too!

CEREALS: Quick and easy ways to raise blood-sugar levels and provide energy to kick start your day. More importantly, they're rich in B-group vitamins essential for a health nervous system.

PULSES/FISH/EGGS/MEAT/DARK GREEN VEGETABLES: A good source of iron. Depression and anxiety can be triggered by anaemia, which is caused by low iron levels.

OATS: These contain complex carbohydrates, which maintain blood-sugar levels and minimize mood swings. They also have tyrosine – a natural substance thought to combat depression.

BANANAS: They're rich in the natural compound tryptophan, which the body converts to serotonin – the 'happy hormone' that reduces anxiety and depression.

OILY FISH: Salmon and mackerel contain omega-3 oils – healthy fats. Not eating enough of these can affect brain chemicals, leading to depression. If you are a vegetarian using extra virgin oil and taking flaxseed or oil of evening primrose supplements are the best equivalent.

SESSION 6

Eat to beat your blues (continued)

BRAZIL NUTS: Studies show low intakes of selenium make people moody and anxious. Just five brazil nuts provide the recommended daily intake.

AVOCADOS: Supply the antioxidant Vitamin E and monounsaturated fats that help lower cholesterol. They're also rich in vitamin B6, which the brain needs to make the feel-good hormone serotonin.

GREEN LEAFY VEGETABLES: These include cabbage and broccoli and contain the vitamin folate. Deficiency is thought to lower serotonin levels.

CHOCOLATE (in moderation!): It contains phenylethylamine and theobromine – substances that make us feel happy when we eat them. Chocolates also hold 'good-mood minerals' calcium and magnesium.

ELPITHA SUPPORT GROUP
SESSION 6

HANDOUT 17

Contacts which may be of help to you	*Contact Number*
Citizens Advice Bureau	As per local area
Cry-sis (helpline for parents with crying children)	020 7404 5011
Home-Start charity (friendship and support offered to families with pre-school children)	As per local area
MAMA (meet a mum association – national helpline for parents who are feeling low)	0181 768 0123
Parentline Plus – help, information and support for parents and families	020 7284 5500
Samaritans	0345 90 90 90

www.livinglifetothefull.com www.overcoming.co.uk

www.depressionalliance.org

www.octc.co.uk (Oxford cognitive therapy centre)

www.youtube.com
(I had a black dog, his name was depression, living with a black dog)

www.self-compassion.org www.mindandlife.org

information@depressionalliance.org

Gilbert, P. (2010) *The Compassionate Mind*. Constable & Robinson Ltd. London

Mindfulness and Stress Reduction Course (origin Jon Kabat-Zinn)

SESSION 6: LOOKING BACK - MOVING FORWARD:

SUPPLEMENTARY BACKGROUND INFORMATION

Throughout the course the participants have been exposed to an atmosphere of compassion, of respect, of acceptance and kindness. Gilbert (2006) explains that the effect of such exposure softens the way individuals look at themselves and encourages a tolerance for imperfection and failure which, like suffering, are unavoidable. Growth and maturity are facilitated through the development of this different way of relating to the self and others. This carries the individual forward as the group comes to a close and the loss of companionship is deeply felt, but where new possibilities of engagement with the world open up on the horizon (Gilbert, 2006).

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www.compassionatemind.co.uk

www.livinglifetothefull.com

www.octc.co.uk

www.youtube.com
(I had a black dog, his name was depression; living with a black dog)

www.self-compassion.org

www.mindandlife.org

www.elpithasupportgroup.org

ELPITHA REFERRAL FORM

Home Start
Support and friendship for families

Date referral received..... **HLW**

Please note that all referrals must be made with the consent of the family. Have you discussed this referral with the family prior to completing this form? **YES / NO**

Criteria for Support:

- Experiencing PND
- Experiencing Low mood

Name of family..... Family Number (scheme use).....
Address.....
.....
..... Postcode.....
Tel. No ..... Mobile .....
Email .....

Please provide some details about the adults caring for the child[ren]:

	Name	DOB	Relationship to child	Comments
Parent/Carer				
Parent/Carer				

Referred by: Date of referral:

Name Role Agency Address E mail _____ Postcode Tel	Please list all agencies involved:

Please √ all that apply to this family:

Lone parent	substance abuse	domestic abuse	mental health issues	learning disabilities	post natal depression	interpreter required	other please specify

Main concerns of referrer (please use separate sheet is necessary for additional information)
.....
.....
Facilitators observations .....
For referrer:
Edinburgh Post Natal Depression Score (needs to be >11 for referral) SCORE:
For facilitator:
Pre Elpitha: PHQ-9 score: GAD-7 score:
Post Elpitha: PHQ-9 score: GAD-7 score:

REFERRING AGENCY RISK ASSESSMENT

Please note this referral will not be processed without the referring agencies Risk Assessment being completed.

Please provide as much detail as possible

Risk	Rate	Comment
What is the access to the house like? (please give brief description, i.e. top floor flat, on road parking)	Good/ Standard/Poor/ Unsure	
Housing and hygiene conditions.	Good/ Standard/Poor/ Unsure	
Are there any known animals in the house?	Yes/ No/Unsure	
Any known violent family members or person that lives in the house?	Yes/No/Unsure	
Are there any known infectious illnesses?	Yes/No/Unsure	
Any known substance/ drug misuse?	Yes/No/Unsure	
Are there any child protection concerns?	Yes/No/Unsure	
Are the family known to the police?	Yes/No/Unsure	

Details of children - (please include details of all children under 18)

Child's name Youngest first	**Gender**		**Date of birth**	**Immigration status**			**Considered to be disabled by**	**Asian or Asian British**				**Black or Black British**			**Chinese or Other Ethnic**		**Mixed**	**White**			**Subject to assessment of needs**	**Child in need √**	**Child care/ protection plan (√)**	Comments
	Male	Female		Asylum seeker	Refugee	Pending		Indian	Pakistani	Bangladeshi	Other Asian	Caribbean	African	Other	Chinese	Other Ethnic	Any mixed	British	Irish	Other White				
C1.																								
C2.																								
C3.																								
C4.																								
C5.																								
C6.																								
C7.																								
C8																								
C9																								
C10.																								

Please complete those boxes which apply to any of the children

Note: the terms above are nation-specific - not all will be relevant in your area

Family needs – Although this project is specifically targeted around PND/Low mood, there may be other contributing factors that need to be taken into account.

Family needs

1.Managing child's behaviour	√	If you have ticked, please tell us why this is a need
2. Being involved in the child(ren)'s development		
3. Coping with own physical health		
4. Coping with own mental health		
5. Coping with feeling isolated		
6. Parent's self-esteem		
7. Coping with child's physical health		
8. Coping with child's mental health		
9. Managing the household budget		
10. The day-to-day running of the house		
11. Stress caused by conflict in the family		
12. Coping with multiple birth/multiple children under 5		
13. Use of services		
14. Other (please describe)		

Details of other members of the household with responsibilities for caring for the children

	Gender		**Date of birth**	**Immigration status**			**Consider themselves to be disabled**	**Asian or Asian British**				**Black or Black British**			**Chinese or Other Ethnic Group**		**Mixed**	**White**		
	Male	Female		Asylum seeker	Refugee	Pending	YES?	Indian	Pakistani	Bangladeshi	Other Asian	Caribbean	African	Other	Chinese	Other Ethnic	Any mixed	British	Irish	Other White
Main Carer																				
Partner living in household																				

Referrer's signature ..... Date .....

Parent's signature ..... Date .....

Thank you for taking time to provide this information which will help us to process the referral.

We are unable to process your referral until we have received this form

We will remain in touch while supporting this family and will contact you when the support ends

If you have any issues or concerns about the referral process or the support for the family please contact **Home-Start Harlow, Unit 19b, The Latton Bush Centre, Southern Way, Harlow, Essex. CM18 7BL. Tel: 01279 451669. email: homestartharlow@btconnect.com**

PATIENT HEALTH QUESTIONNAIRE (PHQ-9) AND GENERALIZED ANXIETY DISORDER (GAD-7)

PHQ-9

The patient health questionnaire is designed to facilitate the recognition and diagnosis of the most common mental disorders in primary care patients. For patients with a depressive disorder, a PHQ Depression Severity index score can be calculated and repeated over time to monitor change.

Scores of 5, 10, 15 and 20 represent cutpoints for mild, moderate, moderately severe and severe depression respectively.

GAD-7

The generalized anxiety disorder is designed primarily as a screening and severity measure for generalized anxiety disorder, the GAD-7 also has moderately good operating characteristics for three other common anxiety disorders – panic disorder, social anxiety disorder and post-traumatic stress disorder.

Scores of 5, 10 and 15 represent cutpoints for mild, moderate and severe anxiety respectively. When screening for individual or any anxiety disorder, a recommended cutpoint for further evaluation is a core of 10 or greater.

All PRIME-MD and PHQ materials were developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues with an educational grant from Pfizer Inc.

Website to obtain PHQ-9 including permission for clinical/research use: www.pfizer.com/phq-9

Elpitha Pre / Post Group questionnaire

Name .....

Date .....

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.....	0	1	2	3
2. Feeling down, depressed, or hopeless.....	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.....	0	1	2	3
4. Feeling tired or having little energy.....	0	1	2	3
5. Poor appetite or overeating.....	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down.....	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.....	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving .around a lot more than usual.....	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.....	0	1	2	3

(For office coding: Total Score _____ = ___ + ___ + ___)

If you checked off any problems, 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**
☐	☐	☐	☐

From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Elpitha Pre / Post Group questionnaire

Name ……

Date ……..

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

ELPITHA SUPPORT SESSIONS EVALUATION QUESTIONNAIRE

(A qualitative questionnaire on the process of group therapy)

1. I came to this Support Group because…
2. The best things about coming were …
3. The most difficult things were …
4. Coming to the sessions has helped me to …
5. I would have liked to have done more about …
6. For the next sessions it would be better if …
7. Now that the sessions have finished I will …
8. Is there anything else you want to say?

WHAT ELPITHA IS TO ME?

A picture created by a group participant
(reproduced with her kind permission)

Home-Start Harlow

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Registered office: Latton Bush Centre, Southern Way,Harlow, Essex. CM18 7BL. Registered charity no. 1110722
Local Patron: Robert Halfon MP. Home-Start UK Patron: HRH Princess Alexandra, the Hon. Lady Ogilvy, KG, GCVO

Home-Start/Health Visitors working together

What is the Elpitha Support Group?

Dear Parent,

Our group is for those parents who have a child or children under 5 years of age, who are struggling with low moods. Some parents 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 Latton Bush Centre and, once your health visitor has referred you or you have contacted us yourselves (ring Home-Start on 01279 451669), 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. We have a crèche and can also provide transport if you need it. Our next group is due to begin ..... until ..... between 10.00am – 12.00 noon.

We look forward very much to spending time with you.

CLAIRE AND DONNA
(Home-Start)

HELEN AND PAT
(Health Visitors)

ELPITHA SUPPORT GROUP FRAMEWORK

adapted from Milgrom J., Martin P., Negri L. (2006) *Treating Postnatal depression: A Psychological Approach for Health Care Practitioners.* John Wiley & Sons Ltd., Chichester

and based on Compassionate Cognitive Behavioural therapy.

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

1. 'Welcome' Icebreaker; Supporting each other; Pregnancy, birth and now; What women say; What is postnatal depression? 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)
6. 'Looking back, moving forward'
   Use of flashcards; Overview of previous sessions; Preparation for moving forward; Future support and contacts; Completion of Evaluation forms; and parting gift to each participant.

Further information may be obtained from the Nursing Times Article 'CBT-based support groups for post-natal depression' (16.10.13 Vol 109 No 41)

The following poem is framed and presented as a gift to each participant at the end of the course

The Beautiful

by Elisabeth Kubler-Ross

The most beautiful people we have known
Are those who have known defeat
Known suffering
Known struggle
Known loss
And have found their way out of the depths

These persons have an appreciation
A sensitivity
And an understanding of life
That fills them with compassion
Gentleness
And a deep loving concern

Beautiful people do not just happen

****

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HOMESTART/HEALTH VISITOR PARTNERSHIP

For the attention of the health visitor

Re: Feedback following attendance at the Elpitha Support Group

Your client:

Each member of the group has been invited to a reunion meeting plus attendance at their weekly Family Group and, should you wish to discuss the following feedback further with us, please do not hesitate to ring either …… or myself. The feedback is based on the comparison of scoring using the Patient Health Questionnaire (PHQ9) and the Generalized Anxiety Disorder Questionnaire (GAD7).

PHQ9 pre group: post group:

GAD7 pre group: post group:

With our best wishes,

Homestart coordinators …… (Health Visitors)

For information

PHQ 9

5	Mildly depressed
10	Moderately depressed
15	Severe depression

PHQ 9 Scores and proposed treatment action

	Depression severity	Treatment
0-4	None	None
5-9	Mild	Observe, repeat PHQ 9 in 4 weeks
10-14	Moderate	Consider counselling/medication
15-19	Moderately severe	Initiation of medication

GAD 7

5	Mild anxiety
10	Moderate anxiety
15	Severe anxiety

ELPITHA SUPPORT GROUP

What mothers have expressed about the Elpitha group:

I can't describe how much you helped me to change not only how I'm thinking but how I'm beginning to see myself

It's nice when someone actually cares about our feelings, makes us feel worthy

I have had a wonderful experience of group therapy. I felt a great connection.

I have found all of you, including the girls in the group and the Home-Start crèche workers, my 'Angels'. You truly made me want to live a happy life.

I was welcomed with no judgements and with such kindness from you to listen and support me with such compassion, yet helping me to learn new tools to take away to make my life better. This was quite the most valuable thing I have ever been a part of.

Thank you for helping me love myself again, at such a difficult time in my life ….post natal depression was the scariest time of my life I have ever faced and I will always have gratitude that Elpitha was there for me at just the right time, and I still believe that this 'saved' me.

You all helped me believe in myself again, and you never made me feel alone during that time it took to feel worth my own life again. So thank you, thank you. Forever I'm truly grateful.

I have learnt not to be so hard on myself when I don't meet my high expectations; I can deal with situations calmly which before would have resulted in anger and I've been able to talk to my partner about it.

I realize I'm a good mother and a good partner and that I should be proud of me as a person. I'm me and that's okay. I'm not perfect but I do my best and that's all I can do.

I am a Mum to two beautiful girls who deserve a happy Mummy and that's exactly what they have now.

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