

Women's Experience of GCBT for PPD

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Abstract

The aim of this study was to identify what women find therapeutically helpful in a Group Cognitive Behavioral Therapy (GCBT) for Post-partum depression and in their challenged developmental process of becoming a mother. The present intervention differed from other GCBT interventions as it included the presence of the women's babies in the group sessions used as an "in vivo exposure" technique. Using a mixed methods design twelve first-time mothers' experiences of the intervention were examined using the Elliott's Client Change Interview. Survey data from Edinburgh Postnatal Depression Scale scores was included to add weight to the clients qualitative reports of change. The results showed that the women through the intervention experienced an overall positive change in their developmental process into motherhood. Especially, the presence of the infants, the group setting, the CBT-techniques were reported to be key factors for the women's experienced change.

Introduction

Giving birth and motherhood are often described as "the greatest gifts". But contrary to the myths of the happy mothering, many women experience periods of sadness and depression following childbirth [1]. In fact, research has found that up to 19% of mothers may experience symptoms of depression during the first three months after delivery [2]. Postpartum depression (PPD) is defined as a form of unipolar depression following child birth where time of onset (within 4-6 weeks after delivery) specifies the suffering [3]. Postpartum depression is typically distinguished from the postpartum blues, which is a common (incidence 40% to 80%), mild, and transient mood disturbance that often occurs three to five days after childbirth and today [4] increased attention to the importance of screening and identifying women with PPD is seen postpartum depression seriously impairs maternal wellbeing and functioning [5]. Its major features include depressed mood, anxiety, compulsive thoughts, loss of control, feelings of inadequacy, inability to cope, irrational fears, fatigue, despair, and in some cases the mother may develop suicidal and/or infanticidal thoughts and plans [6]. The association between PPD and parenting difficulties has been well documented and constitutes a risk factor for long term child development [7,8].

A review documents that psychological treatments of PPD are efficient in reducing depressive symptoms [9], and there is significant evidence that cognitive behavioral therapy (CBT) is effective in treating depression [9,10] including PPD [11]. CBT focuses on helping depressed clients to modify distorted patterns of negative thinking and to make behavioral changes that enhance coping and reduce distress using techniques such as thought records, pleasant activity records, the identification of cognitive errors, behavioral experiments, e.g. "in-vivo exposure" [12]. In-vivo exposure involves confronting a feared objects or situation directly (i.e., in reality, as opposed to imagination) Examples include practicing attending parties. Meeting or other social gatherings to combat the social anxiety disorder. Studies comparing in-vivo exposure to imaginal exposure for situational fears have generally found situational exposure to be the most effective [13]. Mothers suffering from postpartum depression are found to use more

irrational cognitions which supports the choice of CBT in treating PPD [14]. Though effective, individual CBT can be costly, which makes the provision of treatment in group format an alternative. Milgrom et al (2005) found that a 10 week group treatment program involving PPD education, CBT and homework exercises led to a reduction in depression scores on the Edinburgh Postnatal Depression Scale (EPDS). This finding is supported in other studies of Group Cognitive Behavioral Therapy (GCBT) [3,15]. In addition to being more cost effective, group format interventions also have a number of therapeutic characteristics that are not achieved in individual treatment. Groups are found to achieve change through the dual process of emotional experience and reflection in an interpersonal context. Groups provide a support network, reduce isolation and stigma, enable a number of women to be treated at once, they facilitate women to shape coping strategies and to learn from each other and provide an environment to practice interpersonal and communication skills [3]. However, women with PPD are found to prefer individual therapy [16]. This may be due to a preference for the privacy, confidentiality and individual attention that individual treatment affords, but also to the fact that group meetings are logistically challenging for mothers of newborns as group meetings are not flexible [16]. The issue of the women's need for arrangement of childcare is important to consider when treating PPD as this may hinder their participation. In social support programs and psychodynamic therapy programs infants often accompany their mothers [17]. However, in GCBT programs the accompany of infants represents an issue of debate. Some argue that mothers with PPD often have a preconception that they are poor parents and are concerned with mothering the "right" way, particularly in the presence of professionals and other mothers. During therapy the infant may act as a stressor and unable the mother to participate fully in the group program, or process new information and attempt alternative solutions, if she is attending to her baby [18,19]. Thus, short-term CBT is shown to be effective in reducing the depressive symptoms in PPD both when delivered individually and in groups [9]. However, almost no studies of CBT in treating PPD have obtained information on the maternal perceptions of treatment. Scientific knowledge about clients experience of therapy is often absent in studies and it has been

suggested to ask questions like whether the women simply felt better or even liked the intervention [9]. A review of qualitative studies of women's perceptions and experiences of group treatment for PPD identified a total of six studies – only two of these specifically examined GCBT [20]. In one study Morgan et al. (1997) examined an 8-weekly session (2 hours duration) program of cognitive and behavioral exercises with an average of 6 attendees in each group. Results showed that the women experienced to become more realistic in their expectations to themselves, started to rethink different aspects of motherhood and began more often to reach out for help. In Davies and Jasper's study (2004) they examined a 12 weekly session (90 minutes duration) CBT program with 8 attendees in each group. They found that all women experienced positive changes, such as enjoying their baby more and feeling more normal by joining the group. The experience of "feeling more normal" is described by women with PPD as being both the feeling of meeting other women in a similar situation, i.e. "you are not alone" and finding out what is normal for the postpartum period, e.g. feeding issues and emotional instability [21]. Recent research suggests that a very low percentage of women with PPD receive psychological treatment, due to access being limited by cost and waiting times [17,22]. Knowledge and understanding of the effectiveness of key components in therapy may be gained by therapists learning from clients experiences of key factors for change [23] and outcome [24]. Studies of client experience in treating postpartum depression may be important contribution to understand PPD and to develop and offer interventions that are easily accessible to the ones in need.

The objective of this study was to investigate 12 women's experience of a manualized GCBT intervention of six sessions with a duration of two hours over a period of eight weeks. All group sessions included the presence of the women's babies. We aimed to identify what factors the women found most therapeutically helpful in this GCBT program. We were especially interested in their experience of the presence of the babies in the group sessions and whether this would work therapeutically as "exposure in vivo". Further we expected that bringing the babies would make the women's participation in the program less logistically challenging. We examined the women's experience of change i.e. outcome, that included both qualitative and quantitative data sources, and their experience of key aspects of change. We employed a semi-structured interview regarding experience of therapy and assessed depressive symptoms before treatment, at the end of treatment and 7 months post-treatment [25]. This study contributes to our understanding of what women find therapeutically helpful in a GCBT program for postpartum depression. Specifically it contributes with new knowledge regarding the women's experience of the presence of their babies in the group sessions. This is to the best of our knowledge innovative and has not been examined before in other GCBT programs.

Method

The participants

The present study was nested within an ongoing larger study (N=30) examining the relationship between early mother-infant interaction, infant development and infant attachment in an university clinic setting. All participants were primiparous and referred by primary health care nurses. The present subset represents 12 out of the first 15 mothers included, i.e. the participants in the first three GCBT groups (five mothers in each), who had also completed the 7 months

post treatment assessment. Only data from 12 mothers was included in the present analyses, as data from three mothers could not be used for different reasons. In Group A one mother dropped out after the first session, as she did not feel comfortable with the group setting. This also meant that Group A only had four mothers and their infants during the program. A second mother from Group B completed the interview, but had concurrently received individual therapy. This influenced her answers so they did not pertain to the group treatment specifically. A third mother from Group C went abroad for a longer period after intake, and she did not fulfill the inclusion criteria of present depressive symptoms, when she started in the group program.

Inclusion criteria were a) EPDS score ≥ 10 , b) being a first time mother, c) willingness to give informed signed consent to participate in the study, d) infant born healthy at term. Exclusion criteria were: a) immediate risk of suicide, b) psychosis and/or presence of co-morbid bi-polar disorder and c) substance abuse. Two women were prescribed antidepressants before starting the GCBT and they both continued medication during the treatment.

At intake the 12 women had an EPDS mean score of 14.7 (SD=3.9; Range:10-23). The mean age was 31.8 years (SD=3.2; Range:28-37). All participants were employed before giving birth and living in an urban Copenhagen area with a partner. All women had completed education equivalent of American college or university. The mean years of education was 16.09 (SD= 1.04; Range. 15-17). The infants were 6 boys and 6 girls and had a mean age of 85 days at program start (SD= 22.6; Range 44-120).

The Treatment Program

The GCBT program in this study is inspired by the PPD treatment program developed by Milgrom, Martin and Negri. Their program is based on the CBT model for depression and divided into three phases: 1) Behavioral interventions; 2) Cognitive interventions and 3) Relapse prevention and evaluation. Based on Milgrom et al's model a manual for a GCBT program of 6 \times 120 minutes sessions, where infants were to accompany th their mothers, was developed in the present study. This meant that the mothers did not have to find a babysitter, which made their participation less logistically challenging. Further, for mothers suffering from PPD bringing their infants to the group sessions was also considered an behavioral experiment and "in-vivo exposure". Postpartum depressed mothers suffer from feelings of incompetence and anxiety that often lead to isolation and avoidance of bringing the infant into social contexts where other people watch them being mothers [1].

Each group consisted of a leading therapist, a clinical trainee as assisting therapist and five mothers and their infants (one group only had 4 mothers and their infants as one mother dropped out after session 1). The first four sessions were weekly, and the last two were bi-weekly. In the first session a short educational introduction to PPD and the CBT model was given and the women introduced themselves. The program was divided into three phases of interventions:

Behavioral interventions (session 1 and 2; focus on pleasant activities and mood, and on increasing pleasant activities)

Cognitive interventions (session 3, 4 and 5; focus on thinking and cognitive errors, challenging negative thinking and finding ways to reduce negative thoughts and increase positive thoughts)

Closure, evaluation and future "mood" strategies ("what have I learned", "what has been effective", "how do I maintain the positive thinking")

Drinks and snacks were served at every session. All participants were seated in a circle. On the floor in the middle there was a blanket for the infants to lie on. It was possible to feed and change diaper in the room. The women were asked not to meet privately during the treatment period.

The therapists

The leading therapists comprised two female, DK-CBT trained clinical psychologists having between five and 10 years of post-graduate clinical experience. One was the leading therapist in one group and the second in the other two groups. The CBT training consisted of a two-year training program including regularly supervision from two experienced CBT therapists from a DK-CBT centre of excellence. Adherence to the manual and monitoring of the therapies was secured through weekly peer-supervision and case-discussion with colleagues.

Instruments

Client experience interview: Clients were interviewed following Elliott's Client Change Interview Schedule 2010) [26,27]. The purpose of this semi-structured interview was to help clients express their experience of the therapy as freely as possible. After an initial open question, in which the client was asked to speak freely about her experience of the therapy, the interview contained the original questions from the Client Change Interview Schedule [26] and assessed aspects of clients' experience of therapy including: (a) changes perceived by clients that have occurred to them over the course of therapy and (b) clients' understanding of the sources of these changes, including key aspects of therapy. Questions concerning the experience of participating in a research project, of the group, bringing the infant along for therapy, the therapists and the length and frequency of the therapy were added. All 12 interviews were transcribed producing texts ranging from 14 to 35 single-spaced pages.

EPDS: The Edinburg Postnatal Depression Scale [27,28] is a 10-item self-report measure specifically designed to assess depression in the postpartum period. It has a range of 0-30. A cut-off score of ≥ 10 was used as recommended for research in a clinical setting to identify cases of minor depression [27]. The EPDS was used to assess the women's experience of their depressive state by public health nurses during routine visits in the home 8 weeks post partum at referral to the study. The women filled out the EPDS again at the end of the treatment program and 7 months post treatment.

PSE: The women were interviewed using the Present State Examination (Short version for clinical use; The SCAN Advisory Group, 1994; Danish version, WHO SCAN Training Centre, Aarhus, 1995) to screen for the exclusion criteria. PSE is a structured interview assessing ICD-10 diagnostic criteria for a wide range of psychiatric syndromes [29].

Procedure

The intake procedure was carried out by two certified clinical psychologists. It included an introduction to the study and the GCBT program and the PSE interview. Clients were assigned randomly to the groups within the constraints of therapist availability. Duration from

intake to first therapy session had a mean number of days of 53.6 (SD=21.9; 27-92). In purpose of the overall study the women were (shortly after intake) interviewed using the Adult Attachment Interview [30] and mother and infant (at 4 months) were videotaped in a standard face-to face interaction for 10 minutes. The development of the infant was assessed at 4 months [31]. These assessments included a short educational feed-back. At the end of the 6th therapy session mothers again completed the EPDS. No later than 3 week after termination of treatment, the women were interviewed with the Client Experience Interview by 3graduate students, who all had received initial intensive training and supervision. Seven months post treatment the mothers completed the EPDS for the third time.

Analysis of transcripts

The interviews were verbatim transcribed and analyzed using qualitative analyses - a combination of categorization strategies derived from grounded theory [32,33] phenomenological approach to meaning condensation. The purpose of the analytic strategy was to develop rich descriptions of every single case while at the same time to establish an integrated understanding of common meaningful features across the clients. In securing the transparency of this analysis and meaning condensation we describe the phases in this process more detailed.

First phase

The first transcript was analyzed and divided into meaning units independently by all 4 authors. Meaning units are specific parts of the clients' speech that convey a meaningful statement and are assigned an overall code [34]. The authors met to compare and discuss their analyses and differences in delineation of meaning units and assigned codes. For example one mother stated "I now feel that my reactions are more attuned to and consistent with my baby's needs and reactions." This meaning unit was discussed and in agreement between the four authors it was assigned the code "feeling more competent as a mother". Later in the interview the same mother stated "I don't cry that often anymore and I smile more", which again was discussed and in agreement assigned the code "feeling more positive". Based on a discussion of all delineated meaning units a consensual assignment of codes in the entire interview was produced by the four authors. This analytic procedure of an initial phase with an individual coding of meaning units and assigning codes, then meeting in the group of coders to discuss differences in order to reach a consensus regarding coding is frequently used in qualitative analyses [27].

Second phase

Following the procedure in phase 1 the second and third interview were analyzed individually by the authors, who subsequently met to examine the identified meaning units and assigned codes. Codes with similar content were then grouped into categories. Thus, the two coded meaning units in the examples above were grouped together into one category named "Experiences of positive change in one self". Throughout this process we considered what was emerging as "core" categories that seemed to capture the essential nature of the client change experience and had the greatest links with the other categories [33]. For example the above mentioned category "experience of change in one self" was included in the overall cluster "Becoming a mother" as this captured the women's essential experience of change during therapy. The categories and clusters constituted a preliminary and constantly evolving system.

Third phase

In the analysis of the following 6 interviews phases 1-2 were repeated by author 2, 3 and 4 using the computer software NVivo in coding. Through this coding process new codes were added and sometimes the previous wording of the codes were changed to better capture the essential content of the women's experiences. Subsequently all 4 authors met to further discuss and revise the system.

Fourth phase

The first author worked through each of the 9 coded transcripts to further organize the categories and clusters. Notes from the first author and the developing list of categories and clusters were circulated to the other 3 authors, as well as we continuously met to discuss the list in relation to each transcript as it was worked on. This phase also included a selection of categories, used for more intensive exploration as well as we chose to refrain from reporting data regarding the women's personal history and their experience of participating in a research project. Once this procedure (phase 1-4) was completed the result was an overall system with 7 categories organized in to 3 clusters, which was used in the coding of the last 3 interviews. The clusters and categories that emerged through the analyses were (Figure 1).

Cluster 1: Becoming a mother:

- Experience of change in oneself
- Experience of alleviation of the depressive symptoms

Cluster 2: The group as a supporting and normalizing environment:

- Experience of the groups environment
- Experience of the others "being like me"

Cluster 3: Key aspects of therapy:

- Experience of the presence of the infant
- Experience of the CBT techniques
- Experience of the therapeutic setting.

Validity issues in the qualitative analyses

To ensure that our interpretations of the data were trustworthy, we conducted a number of credibility checks. We ensured that we reached consensus [34] through checking individual interpretations among the researchers. We have provided rich examples of the data to enable the reader to judge the fit between the data and our understanding of them. Finally, to add weight to the clients' qualitative reports of change we include quantitative data reported by the clients on the change in their experience of depressive symptoms.

Statistical analyses of the survey data of depressive symptoms

Using the Edinburgh Postnatal Depression Scale the 12 women reported their depressive symptoms before treatment, at the end of treatment (i.e. the sixth session) and 7 months post treatment. To add weight to the reported experiences of the women regarding reduction of the depressive symptoms in the period of and after the GCBT

program the three means of the EPDS scores will be compared using repeated ANOVA. All analyses are performed using SPSS version 20.

Results

The result of the analysis of the interviews was an overall structure with 7 categories that were organized in to 3 clusters as presented in Table 1. Cluster 1 "Becoming a mother" represents the women's experience of change (i.e. outcome) and Cluster 2 "The group as a supporting and normalizing environment" and Cluster 3 "Key aspects of therapy" represent their attribution of cause and important factors for the change process they experienced

Cluster 1: "Becoming a mother"	Experience of change in one self
	Experience of alleviation of the depressive symptoms
Cluster 2: "The group as a supporting and normalizing environment"	Experience of the group environment
	Experience of the others "being like me"
Cluster 3: "Key aspects of therapy"	Experience of the presence of the infant
	Experience of the CBT techniques
	Experience of the therapeutic setting

Table 1: Clusters and categories of client experience.

Cluster 1- Becoming a mother

Change in experience of one self: The most prominent theme in the interviews was the women's experiences of an overall positive outcome in relation to their developmental process of their transmission into motherhood. This is represented in the cluster named "Becoming a mother". All 12 women stated they had become more competent in taking care of their child, e.g. ID12: "I'm no longer afraid that she will cry, when I'm in public places. Before, I couldn't cope with her crying. Now I'm better at handling it". In describing this experience of change, seven women explicitly used the word "mother", e.g. ID4: "Now I'm more secure in my role as a mother. It's not that I've become another person, but I've become more than what I was. My horizon has been enlarged and my emotional register has expanded".

Experience of alleviation of the depressive symptoms: All 12 women experienced alleviation of the depressive symptoms, such as crying less and becoming more positive during the treatment period exemplified in this statement by ID6: "I cry less. I've moved away from that black hole.... In the beginning I had to fight so hard not to be sucked down in to that black hole. Now I feel like the black hole is there somewhere. Sometimes I get closer to it, but it's much easier for me to move away from it".

Cluster 2 - The group as a supporting and normalizing environment

Experience of the group environment: In general the group was experienced as a supporting environment, e.g. ID9: "It was a room of freedom and acceptance, where you didn't feel judged. You didn't need to explain - you dared to be honest. You might scare other people away, if you tell them how you really feel. In the group we all felt that way". Five women described an initial reluctance to participate in a group treatment (ID 2,3,7,9,12) and four out of these also described more mixed experiences of the group. ID2 found it difficult and

anxiety-provoking to tell other people of her problems. ID7 felt it overwhelming to be involved in the group and felt she almost did not have the energy, but at the same she felt it as a liberation to meet the other women. ID9 found it hard to concentrate on the stories of the other women and ID12 was nervous about sharing her story with people that she didn't know, as she had always been nervous when meeting new people.

Experience of the others "being like me": Eleven women explicitly stated that meeting other women in the same situation was a positive and normalizing experience, e.g. ID6: "Most important to me has been meeting other women, who could understand my situation and how I felt. Of course it's not nice to see others feeling sad and depressed. But it was good for me (client laughs quietly) as I could see someone feeling like me. It means that you are not alone. It was normalizing in a way - because I feared I was going mad. And I could see myself in all these women. That identification has been very important to me".

Cluster 3- Key aspects of therapy

The presence of the infants: Bringing the infant along for therapy was experienced as challenging, however a majority of the women found it to be overall positive. Six women emphasized that for practical reasons it made it possible for them to participate at all. Three women described the feeling of success in bringing the infant, e.g. ID2: "I thought I couldn't manage, but it turned out that I was able to. I became happier every time I left home and it actually went well. Those were little experiences of success. But I felt it was a major challenge". Nine women expressed that the presence of the infants led to an experience of normalization of themselves and their babies and that it was positive to see other mothers handling their babies. ID12 described the fear of her baby crying during therapy and her not being able to comfort the baby and how this would be shameful. As this happened to another women, she felt glad that it was not her. When her child started to cry in session 3, she was able of coping: "I now felt it was okay and completely normal. Other children cry as well". Three women described how the infants sometimes acted like "ice-breakers", as a "comic relief" and as a positive distraction, e.g. ID8: "Sometimes the infants "softened the situation" - lying there in the middle of the circle". We sat there - all very sad, but they - it may sound like a cliché - in some way they brought life and progression into the therapy- just being new little lives themselves... They made us smile. They were also the reason and the motivation for us being in treatment. The biggest motivation for me has been to become a better mother for the sake of my child. He has been the obvious reason for me being there".

Downsides to the presence of the infant were also reported. E.g. missing out on something one would have liked to hear (ID10) and ID3 felt that it was hard to cope with herself, her own child and the other children. Three mothers experienced the presence of the infants mainly as negative: ID6 expressed that she did not get the chance to participate as much as she wanted, that taking care of the baby took up too much time (ID5) and one would have preferred not to bring her child (ID9).

Experience of the CBT techniques

Eleven women described the cognitive techniques, such as the identification of cognitive errors, techniques for stopping automatic negative thinking and becoming better at focusing on positive things as being "concrete" and "tangible" and significantly helpful, e.g. ID2: "The greatest help was to be reminded to do good things for myself".

ID11 stated "I can control my thinking now, I try to take off the negative glasses and not worry about the future or blame myself of being a bad mother". ID1 described how she became aware of her ways of thinking and developed a faster way of stopping her negative thoughts. She also described how the other women telling of their problems made it possible to identify cognitive errors similar to her own. Four women would have liked to have learned more CBT techniques (ID 2, 4, 5 and 6), e.g. ID2 stated "There was a lot of it that I already knew, and in some ways the therapy was mainly like a room of freedom, and I was disappointed of the lack of specific techniques introduced to us".

Experience of the therapeutic setting

All women expressed they would have preferred more therapy. Four women accentuated how the therapy was at risk of becoming superficial due to the short duration, e.g. ID2 "When you have such a short treatment it is hard to open up". The issue of talking time per woman was explicated by seven women, e.g. ID2: I was afraid of taking too much time and space in the group", ID3: "Sometimes you could leave a session without having said much, but that worked because it turned out to be fairly divided in the end". ID9 experienced the time to be too short and felt that she didn't have the space and the help she needed. The women's experiences of the therapist were generally positive, e.g. they made sure everyone was heard, the chaos created by the infants was relieved by therapists maintaining focus, they were efficient in reframing and setting up new perspectives and in identifying cognitive errors. However, two women (ID2 and ID4) experienced the therapist mixed. ID4 found the therapists to facilitate a secure setting, but also expressed frustration by failures of the therapists to sum up common themes among the participants. ID2 would have liked the therapists to introduce more techniques (Figure 1).

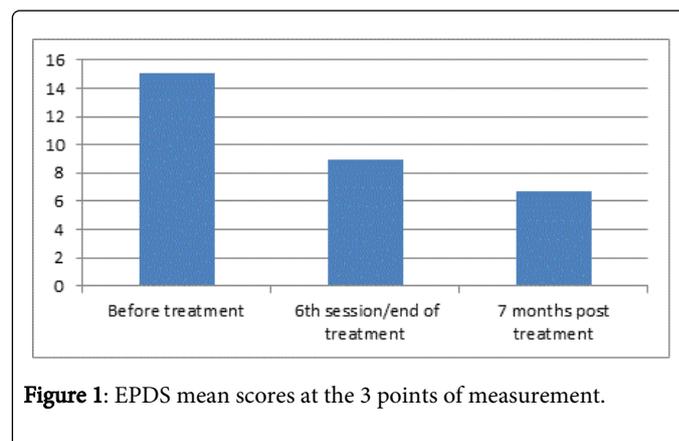


Figure 1: EPDS mean scores at the 3 points of measurement.

Summary of Results

All 12 women reported to experience a positive change in their developmental process into motherhood and they experienced an alleviation of the depressive symptoms. This is supported by the finding of a significant reduction in the level of depressive symptoms as assessed by the EPDS. All women described the group, the meeting with other women and the CBT techniques as key aspects for the experienced change. The presence of the infant was experienced as a challenge, but for a majority of the women it led to a feeling of normalization of themselves and their babies. However, all women

would have liked the program to be prolonged and a subgroup of 3 women (ID2, 9 and 12) reported more mixed and negative experiences. These were mainly related to talking about their problems within a group, amount of talking time, lack of CBT techniques, duration of treatment and the presence of the infant.

Discussion

In the present study we examined 12 women's experience of a short term GCBT program using The Client Experience Interview. This program included the presence of the infants in the group sessions, both for logistic reasons but also to be evaluated as an in-vivo exposure technique. Further we examined the level of the women's depressive symptoms assessed using the selfreport questionnaire EPDS before, during and post treatment.

The presence of the babies as a important factor for change

In GCBT programs the presence of infants represents an issue of debate. Some have argued that during therapy the infant may act as a stressor and unable the mother to participate fully in the group program, or process new information and attempt alternative solutions, if she is attending to her baby [19]. However, part of the rationale for including the infants in the present study is that we have found it to be a limitation that the most important factor for the woman's mental state is "left outside" during a CBT treatment. In most psychodynamic based mother-infant therapies infants are present and an important part of the therapy.

Women suffering from postpartum depression have feelings of incompetence and anxiety which often lead to isolation and avoidance of bringing the infant into social contexts where other people watch them being mothers [1]. CBT programs have proven efficient in treating depression, and especially the cognitive techniques are experienced by clients to be the most helpful factors for change in therapy [35-37]. Thus, another part of the rationale for the presence of the infant in the presents study is that we considered that this could work as the classical cognitive technique of "in-vivo exposure". This was confirmed by the women in the present study who reported the presence of the infants to be a challenge, but overall they found the presence of the infants positive. A majority of the women described specifically the effect of the exposure in reporting the feeling of success related to actually be able to bringing the infant along. They also described the experience of normalization and positive change in their experienced motherhood by seeing the other mothers with their children. A last part of the rationale for this new design with including the presence of the babies is the commonly reported unacceptability of group therapy for PPD which may reflect the realistic barrier of attending regularly scheduled groups, while caring for an infant [17]. Considerable time and commitment is required from CBT participants and approximately 10% to 40% fail to complete full treatment [35]. Six of the 12 women explicitly confirmed that bringing the infant – for practical reasons - made it possible at all for them to participate in the program.

The group format and the cognitive techniques as important factors for change

A majority of the women in the present study reported the experience of the group as supportive and the experience of others "being like me" to be key factors for change. CBT groups offer the participants the option to learn from the other group members and

from what is shared within the group. One example is that participants may see more clearly cognitive errors when exposed and shared by other group members [14]. This is an aspect which is explicitly described as experienced as helpful by more participants in this study. Groups are also found to achieve change through the dual process of emotional experience and reflection in an interpersonal context. Further, they provide a support network, reduce isolation and stigma, they facilitate women to shape coping strategies and to learn from each other and provide an environment to practice interpersonal and communication skills [3]. The groups in the present study also included 5 babies in each of the three groups. The babies themselves – when they were awake and lying on the floor – interacted with each other and sometimes acted as a positive distraction for the mothers, as stated by one participant. A majority of the women expressed that the infants being part of the group led to an experience of normalization of themselves and their babies and that it was positive to see other mothers handling their babies. More women reported that the experience of fear and shame of not being able to comfort their baby and seeing other mothers with crying babies led to shared feelings of frustration and anger, but also normalization. As one mother stated "Other children cry as well".

As group treatment is less resource intensive than individual therapy, it may be a potentially resource- and cost-effective treatment solution. Whether therapy in group format is superior in effectiveness compared to individual therapy is not clear [38]. And it may be argued that GCBT is more effective than individual CBT since more people get treatment at the same time [14].

Within CBT the role of therapists is to help clients to focus on specific problem areas, to teach clients how to identify, evaluate and respond to dysfunctional thoughts, beliefs and behavior and, in so doing, help them to learn to become their own therapist [38]. Likewise, the CBT techniques were described as key components in the positive change the women experienced during therapy in this study. This is similar to a finding in a qualitative study by Clarke, Rees and Hardy (2004) evaluating a short term individual CBT program for depression where they identified a significant cluster they named "the big idea". This cluster included clients' experience of particular therapy techniques e.g. the CBT model of depression and understanding patterns and core beliefs.

A subgroup in the sample

A subgroup of 3 women (ID 2, 9 and 12) was identified as having more mixed and negative experiences than the rest of the women. These mainly related to the group setting (ID2, 9 and 12), the presence of the baby (ID9), the therapists (ID2), lack of CBT techniques (ID2) and duration of the program (ID2 and 9). Two of these women, ID2 and ID12, had continued elevated levels of depressive symptoms at the end of treatment. ID2 had an EPDS score of 14 and ID12 had one of 12. The reasons for these women's more negative experiences of the program and for not profiting as much compared to the other women may be complex. At inclusion they had EPDS scores of 17 (ID2), 13 (ID9) and 14 (ID12), so they were not the most severely depressed women in the sample, which could have been part of the reason. However, both ID2 and ID12 expressed an initial reluctance of participating in a group setting. They both underlined that this reluctance was not specifically related to this group, but was as part of a more general tendency towards social anxiety. Likewise the client who dropped out of treatment after the first session also felt uncomfortable with exposing her problems in a group. This issue may

point to a general limitation of groups therapies, but also to a limitation of the present GCBT program. Due to the short duration of this program the group needs to settle as a secure and supportive environment already from the first session. Clients with traits of social anxiety may not be able to cope with this. In the present study clients were included based on their depressive symptoms [39-42]. Personality characteristics were not considered when forming the groups as the women were assigned to the 3 groups within constraints of therapist availability. However, it may be imperative to consider for whom group treatment works as some postpartum depressed women lacking in social skills and/or in energy may be unable to benefit from treatment of such short duration in a group setting [16].

Generalizability of the study

Obviously, the small sample size and the limited client population (i.e. all 12 women were well educated and were living with a partner) are limitations of this study and thus a challenge to the generalizability of the women's reported experiences of this GCBT program [43-47]. Further, as this GCBT program aimed at women suffering from postpartum depression was specifically designed to include the presence of infants, which is not typical in GCBT for PPD, it naturally delimits the generalizability of the results from this GCBT program to this setting.

Conclusion

From this examination of 12 women's experience of a GCBT program of 6 sessions including the presence of the baby in the group sessions, which is an innovative design in relation to GCBT programs, we conclude that the babies being present work as "in-vivo exposure" and impact as a key factor for change. We conclude that the women as an overall outcome experienced a positive change in their developmental processes of becoming mothers. And they experienced an alleviation in the depressive symptoms that also could be seen in the data from the women's self report of depressive symptoms [48,49]. As key factors for the experienced change the women, besides the presence of the babies, identified the group setting and the cognitive techniques. The subgroup that reported more negative experiences of the GCBT program may indicate that further assessments of personality traits e.g. traits of social anxiety could be important when planning groups. Given the high prevalence of PPD and the negative effects on women and infants, this study of what women actually experience as helpful in therapy contributes to the development of community based interventions for postpartum depression [50,51]. Interventions that not only help the mothers overcome their depression but also help them in the transitional developmental process of becoming a mother.

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