Delivering the Mellow Bumps attachment-based intervention

James Fargie
Development Officer, Mellow Parenting

Sarah Breustedt
Development Assistant, Mellow Parenting

This paper provides an insight into the factors that influence the successful delivery of an antenatal therapeutic group and we emphasise the importance of supervision and reflective practice when delivering a group intervention. We found that although practical factors are important in successful group delivery, psychosocial factors should be given at least equal consideration.

Mellow Bumps is a six week, group-based antenatal intervention designed to support parents-to-be with additional health and social care needs. The intervention has been shown to reduce anxiety and depression of mothers in pregnancy (Waugh, 2012) and promotes connection with the baby before birth.

In our experience, there are common barriers to services delivering group-based interventions, including availability of a suitable venue, provision of childcare and access to funds for refreshments, materials and travel for the participants. The nature of group intervention encourages open discussion between peers which can facilitate disclosure and associated painful or difficult emotions. If these emotions and stories are heard, contained and processed effectively within the group, a rich and helpful experience is created. As practitioners, we must be able to facilitate this process and be able to monitor and process our own responses; having supervision 'space' to reflect on this, we would argue, is therefore vital to delivering the best possible group experience for parents-to-be.

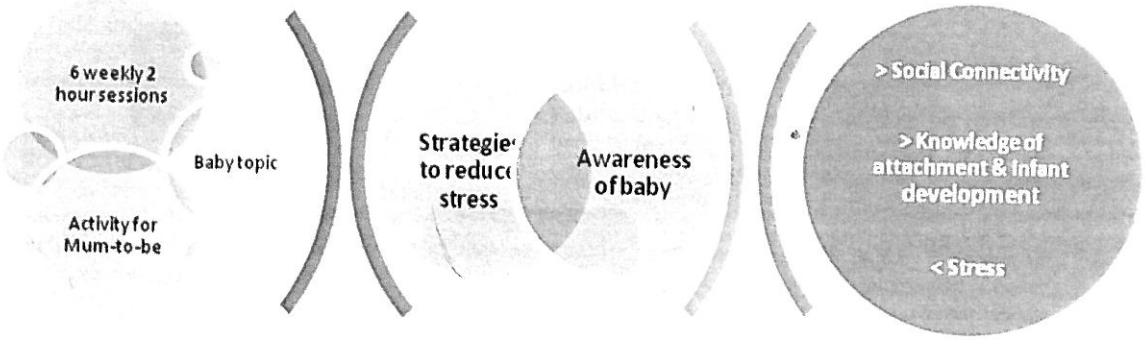
GROUP FACILITATORS

Both authors are MSc graduates in Applied Psychology for Children and Young People, University of Edinburgh. In addition to working as Mellow Parenting Trainers and Practitioners, we are Child and Adolescent Therapists practising in Children and Adolescent Mental Health Services (CAMHS) in Glasgow, UK. We are trained in cognitive behavioural models of psychological assessment, formulation and intervention, and in delivering group programmes including Incredible Years, Triple P and Mellow Parenting.

CHARACTERISTICS OF PARTICIPANTS

All participants were white Caucasian and from the West of Scotland. All were referred by a local drug and alcohol management project and as a consequence, were engaged in a Methadone programme. All three mothers had had children removed by social services in the past.

FIGURE 1:
Mellow Bumps – Aims and Structure



Pseudonym	Age	No. of group sessions attended	Birth circumstances	Child Protection Outcome
Lauren	28	6/6	Baby girl born at term plus 14 by caesarean section.	Baby's name was not placed on the Child Protection register and family agreed to work with services voluntarily.
Anna	32	3/6	Baby boy born at 38 weeks.	Baby's name was placed on CP register at a Pre-Birth Conference and was placed into Foster Care at birth.
Sharon	27	4/6	Baby girl born at 39 weeks.	Baby's name was not placed on Child Protection register and parents worked with services on a voluntary basis.

TABLE 1: MELLOW BUMPS DEMOGRAPHICS OF GROUP PARTICIPANTS

REFLECTIVE MODEL

It is best practice for mental health practitioners to use supervision to reflect upon their experience. We engaged in weekly peer supervision and participated in a reflective supervision session with a Consultant Clinical Psychologist. A core component of the reflective process was thinking about our use of skills as practitioners: use of warmth, appropriate language, establishing and maintaining boundaries, quality of interaction with the participants and fidelity to the intervention model. Reflective practice encourages 'learning through doing' and promotes critical thought, which in turn can contribute to innovation and improved practice (Finlay, 2008). We used the Gibbs Reflective Cycle (Gibbs, 1988) as the model to provide a structure for our learning (Figure 2).

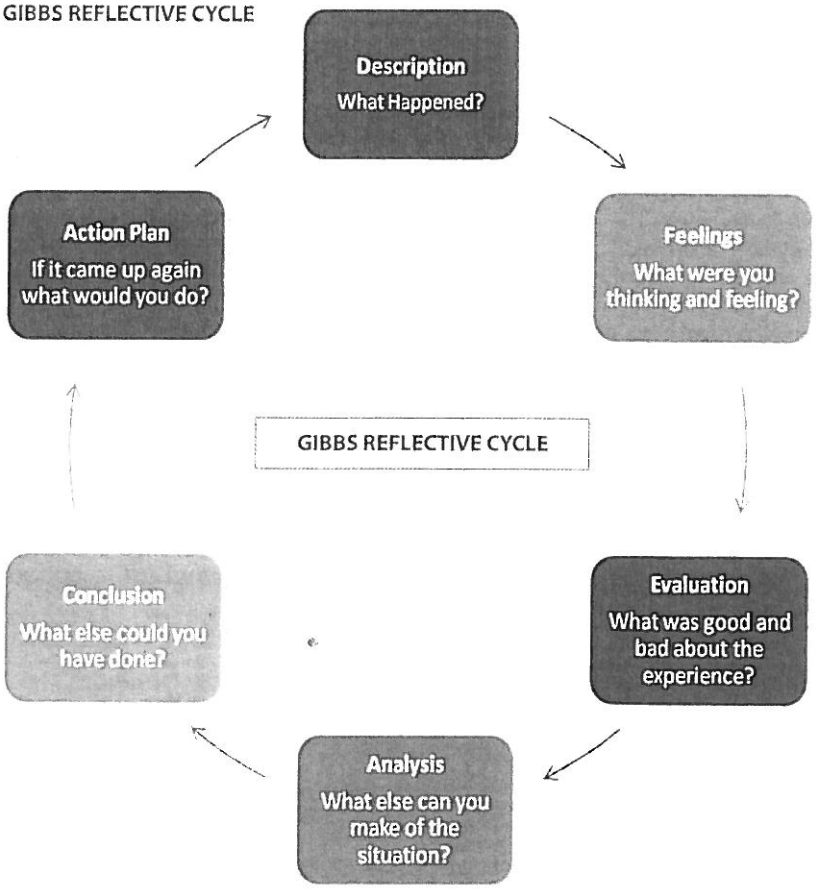
FINDINGS AND REFLECTIONS

We recorded our reflections and grouped the most common findings into three areas; concerns relating to participants' complex circumstances, group system in relation to external system, creating boundaries, managing and communicating boundaries effectively.

A) CONCERNS RELATING TO PARTICIPANTS' COMPLEX CIRCUMSTANCES

During referral processing and prior to meeting the participants, it was apparent that the women's

FIGURE 2: GIBBS REFLECTIVE CYCLE



histories and current circumstances were complex and this raised anxieties on a number of levels. Firstly, from an engagement perspective, we felt acutely aware of the professional-client power imbalance and were keen to diffuse this as much as possible in order to achieve a nurturing and supportive alliance with the group members. In addition to this, we had concerns that the participants' current difficult circumstances would make it harder for them to engage and commit to attending; for example, two out of three mothers were not living in permanent tenancies. We wondered if there could be possible conflict between group members on the basis that they might have encountered each other in the past as all three had accessed homelessness and addiction services in Glasgow City. In order to find out more, we arranged to meet the mothers-to-be in their own homes prior to the beginning of the group. This allowed us to meet in a more informal context than a service-based appointment could offer and to demonstrate that we were committed to involving them by going to their home. After each session we would use de-brief to reflect upon the group process and provide peer feedback to ensure that we were being genuine and open in our approach.

B) GROUP SYSTEM IN RELATION TO EXTERNAL SYSTEM

After the third session, it became apparent that for all of our participants, we were one of up to ten service providers including Probation, Social Work, Health and Addiction Services. This placed us in a delicate position in terms of how we differentiated ourselves from other services and what we could and could not share with them. Confidentiality and understanding how Mellow Bumps fitted into the range of services were important to the group. Establishing group rules provided an opportunity for us to define boundaries around limits of confidentiality, but also to separate ourselves from probation or social work services. The stated purpose of the group was to provide a space to learn about stress reduction and connect with the baby, not for us to assess their suitability as mothers. We were asked by each group member to be present at their Case Conference Reviews and we were careful to manage expectations of what our input would be to the wider assessment process and to frame attendance as moral support. We were asked by Social Work to disclose information about what the mothers had said during the group, and especially how often they had attended. We felt that attendance at the group was seen by Social Work as one indicator of engagement or cooperation, and therefore in a relatively subtle way, the women were coerced to attend.

C) MANAGING AND COMMUNICATING BOUNDARIES EFFECTIVELY

By creating a comfortable, non-judgemental environment, the mothers were able to engage with relaxation and learn practical techniques to promote interaction with their unborn child. A further advantage of the nurturing aspects of the group was that the women were able to talk openly about worries they had about pregnancy, birth and parenting. The group also reflected on negative past experiences and were able to identify the impact they can have on present expectations and behaviour. Given the complexity of the participants' circumstances, we were faced with the discomfort of wanting to provide help and solutions while being aware of the limitations of what we could or should do. Our concern was that our actions could have a negative impact upon the continued engagement of the participants. We introduced techniques to reduce fears about interacting appropriately with their baby, helped them think about who could support them when the baby was born and practised strategies for managing anger and frustration. We also tried to be clear and realistic about what the group could not help with; for example, the group would not negate any effects of methadone upon their unborn baby nor would attendance at the group be likely to be a deciding factor in the decisions of Child Protection meetings. The mothers-to-be appreciated honesty as they had developed unrealistic expectations of services in the past and had lost trust in practitioners as a result. It seemed that talking about difficulties and being heard was more important than being 'fixed' or promised a solution.

CONCLUSIONS

Mellow Bumps is an excellent tool which provides a structure for discussing parent-infant interaction and managing emotions with groups of parents. However, facilitators have to balance competing demands: maintaining fidelity to the programme, managing expectations of services users and services, supporting clients to engage in group work and processing the emotional content of the group discussions. This balancing act can place pressure on practitioners and may cause them to question their skills; we found supervision was helpful in acknowledging and diffusing this pressure. Our experience shows the value reflective practice has for practitioners delivering therapeutic group work. Practitioners should be trained in reflective practice and supported to implement it. One way to ensure this is to provide regular appropriate supervision. Managers and commissioners should therefore take consideration of not only the efficacy of the intervention, but also the reflective skills of practitioners when deciding what models of working to implement and the continued professional development of their staff.

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