

HAPPY MOMS AND HAPPY BABES GROUP PROGRAM

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Dedication

This final project is dedicated to all mothers who commit their lives to providing life, love, and nurturing to their children. It is my hope that this project will empower women to become advocates for their own health and well-being. It is also dedicated to my husband, Jagdev Singh Shahi, and my daughters, Deeyah Kaur and Meera Kaur Shahi. Thank you for your patience and support of the many hours I have spent in the pursuit of my degree. Last but not least, I dedicate this degree to my parents especially my mother, Manjit Kaur Ludu, who has always supported me in every aspect of my life. I am grateful for your wisdom, devotion, and relentless nurturing.

Abstract

Recent studies have shown a link between maternal psychological health and prenatal outcomes. Happy Moms and Happy Babes is a six session psycho-educational group counselling program. Its design provides education for expectant mothers on the subject of potential risks of stress during pregnancy, opportunity to engage in interpersonal learning, a venue to share concerns with other expectant mothers, access to emotional support from qualified professionals, and practice in stress reduction techniques. These educational opportunities are enveloped in the experience of group support. The group counselling manual provides lesson plans and handouts for organizing and facilitating the Happy Moms and Happy Babes Group Program.

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Chapter I

Society still upholds the myth of the supermom, the woman who is always in control, happy, self sacrificing, and rarely stressed. The supermom phenomenon and the desire for a perfect pregnancy in our culture are heavily rooted in Eurocentric values and beliefs in which mothers are expected to “do it all” and “do it alone.” With the postmodern era many mothers are working outside the home and doing most of the work within it. While postmodern mothers are pursuing education and careers, the role of caregiver and homemaker are still present for most mothers. For contemporary mothers the need to balance the many roles in their lives contributes to additional pressures.

The supermom syndrome starts as early as pre-pregnancy where women are expected to eat perfectly, not drink, exercise and the guilt that surrounds that if we don't do it right can be huge and potentially obsessive. Women are also expected to share only the positive emotions and pacify the negative ones. The following is a personal excerpt of some of the thoughts and feelings that I experienced during the course of my first pregnancy: “This is the best time of your life and you must be happy! Why are you crying when you should be happy? Aren't you happy? You're not allowed to feel negative emotions”How could I resent this child so much at times and then love him or her more than anything?

My experience of motherhood differs vastly from that of my mother's generation. Mothers in the 21st century have access to one another's stories and, thanks to those women who have been brave enough to share their stories, the experience of pregnancy and motherhood has changed from our foremother's time. Despite these changes in our

perspective however, the myth of supermom is still prevalent and women are still expected to share only the positive aspects of pregnancy and motherhood.

Pregnancy and birth are natural life and health processes for most women. The vast majority of women experience healthy pregnancies and healthy babies. At the same time, pregnancy and birth are the most extraordinary and personal of human experiences.

During the course of pregnancy most women will be provided with an abundance of advice and warnings. Most of this is conflicting and rigid advice and implies that if an expectant mother doesn't do things perfectly she is putting herself and her baby at risk. (The Boston Women's Health Book Collective, 2008).

At the beginning of pregnancy most women realize that their pregnancy and upcoming birth transcend the sole physical experience. They will recognize that their physical needs are attended to but their emotional needs are dismissed or seen as inconsequential.

When a woman becomes pregnant she may experience many powerful psychological changes. During the exciting, yet vulnerable, time of pregnancy expectant mothers may feel an increase in emotions and thoughts including; ambivalence, sadness, anger, fear, worry, loneliness, and shock. Most women have family, friends, or other social support to help them through the course of pregnancy, yet some women may feel the need for additional support outside of their immediate network to allow them to express some of their negative emotions (doubt, resentment, and anger). These unexpressed negative emotions coupled with the conflicting advice from others and the natural course of pregnancy can cause many women to feel stressed, overwhelmed and

tired during this time. Consequently, it is essential that pregnant women find support to care for their emotional, mental and physical needs.

The Happy Moms and Happy Babes psycho-educational group counselling program is designed to respond to the distinct needs of expectant mothers experiencing stress. During pregnancy women undergo many changes and challenges therefore it is essential that women find support to foster resiliency. Women who have support during pregnancy cope better with stress and are less likely to feel anxious or depressed (Brown, 1985; Collins, Dunkel-Schetter, Lobel, & Scrimshaw, 1993; Feldman, Dunkel-Schetter, Sandman, & Wadhwa, 2000; Hall, 2004; Hoffman & Hatch, 2000; Koeske & Koeske, 1990; Smith, Rosenheck, Cavaleri, Howell, Poschman, & Yonkers, 2004; The Boston Women's Health Book Collective, 2008). Support groups for pregnant women can provide the social environment for supportive friendships, education, and practical information.

The Happy Moms and Happy Babes Group Program provides expectant mothers the opportunity to experience psychoeducation relevant to stress, engage in interpersonal learning, share concerns with other expectant mothers, access emotional support from qualified professionals, develop social relationships with other mothers, and practice stress reduction techniques. When complete this psychoeducational group counselling program will be accessible to counselling and mental health agencies and those that provide professional health care to pregnant women.

This paper will first, provide a rationale for this project. Second, present a literature review identifying stress during pregnancy and its implications, both in utero and in infants and children and adulthood. Third, discuss research that identifies the need

for social support during pregnancy and the benefits of group counselling for expectant women experiencing stress. Fourth, based on the literature review a project suggesting a psychoeducational group counselling program for expectant mothers is proposed. This proposal includes group goals, objectives, session themes, and evaluation criteria. In addition, group structure, membership criteria, group organization, marketing, and ethical considerations will be examined. A manual presents lesson plans and handouts for six weekly sessions. Session themes will include the connection between stress and illness, coping strategies for stress, and relaxation techniques. The information in the program will be sufficient for future facilitators to offer the group session with minimal preparation.

Rationale for the Project

It has long been a tenet of folk wisdom that maternal stress during pregnancy can affect the unborn child. The importance of prenatal environmental factors for the development, behaviour, and health of infants and children dates back to Sir Thomas Browne (1642) when he stated:

And surely we are all out of the computation of our age, and every man is some months elder than he bethinks him; for we live, move, have a being, and are subject to the actions of the elements, and the malices of diseases, in that other World, the truest Microcosm, the Womb of our Mother (as cited by Van den Bergh, Mulder, Mennes, & Glover, 2005, p. 1).

The effects of toxins on the developing fetus have been linked to behavioural, emotional, social, and neurological/cognitive development in both animal and human studies (Istvan, 1986; O'Connor, Heron, Golding, & Glover, 2003). In the past sixty

years there have been a growing number of studies suggesting that stress in pregnancy should be added to the list of antenatal risks affecting fetal and child development (Van den Bergh et al., 2005).

Treating anxiety, depression and stress during pregnancy could have protective effects on the mother and subsequently on the fetus (DiPietro, Hilton, Hawkins, Costigan, & Pressman, 2002; King & Laplante, 2005; Lobel, DeVincent, Kaminer, & Meyer, 2000; Ruiz & Avant, 2005). According to Ruiz and Avant (2005), little research is available to support evidence-based interventions for prenatal mental health.

Adverse Outcomes of Stress during Pregnancy

There are a number of recent studies that, after controlling for potential confounders, have examined the effects of prenatal maternal stress in humans. Results from these studies suggest a strong relationship between maternal psychological health and neonatal outcomes (Van den Berg et al., 2005), establishing a conclusive link between maternal psychological stress and its resulting maternal biological response and the adverse outcomes on the neuroendocrine and immune systems of the developing fetus (Ruiz & Avant, 2005). Researchers have examined the effects of stress on pregnancy and have presented an exhaustive list of the harmful effects of maternal stress on perinatal outcomes (Davis & Sandman, 2006; Dayan, Creveuil, & Marks, 2006; King & Laplante, 2005; Lobel et al., 2000; O'Brien, Schachtschneider, Koren, Walker, & Einarson, 2007; O'Connor et al., 2003). Prenatal maternal stress has been linked to preterm delivery, low birth weight, prenatal brain development, negative temperamental fetal behaviour, and emotional, cognitive, and behavioural regulation problems in children. Many of these health related issues will have far reaching effects in their lives, possibly into adulthood.

Psychoeducation and Mental Health

Mental Health practitioners can provide psychoeducation in stress reduction techniques consisting of yoga, relaxation training, and meditation. Additionally, the findings of the available research suggest clinical implications for counsellors, obstetricians, midwives and other health care professionals involved in the care of pregnant women. Appropriate knowledge and training in dealing with mental health issues for pregnant women is necessary for the health of both the mother and her child. Research findings indicate that more support and psychoeducation needs to be provided to expectant mothers, obstetricians, nurses, social workers, therapists, and counselling paraprofessionals. A multidisciplinary approach with maternity, social, and mental health services is warranted in order to provide optimal care (Hollins, 2007).

Social Support and Pregnancy

Corey and Corey (2006) stated that group therapy is as effective as individual therapy for the treatment of psychological problems. They suggest that psychoeducational stress management groups are useful because they embrace an atmosphere, within a group context, that allows individuals who often feel isolated, to validate each other's experience and find power in that connection. Furthermore, they stated that "group therapy provides a natural laboratory that demonstrates to people that they are not alone and that there is hope for creating a different life" (p.5). The social environment of the group is a catalyst to hope, interpersonal learning, and universality. Social support has been established as a mediator between stress and healthy pregnancy (Anhalt, Telzrow, & Brown, 2007). Furthermore, Feldman et al. (2000) stated:

During pregnancy, social support is considered essential to the health and well-being of the expectant mother. The provision of emotional, informational, and material resources may mitigate the physical and psychological strains associated with pregnancy (p. 715).

The adverse effects of stress during pregnancy and the buffering effect of social support provide a compelling case for a psychoeducational group intervention for expectant mothers. Expectant mothers who perceive they have more social support may in turn seek health-related information (Feldman et al., 2000).

Psychoeducation and Group Support

Women suffering from mental illness need appropriate treatment during pregnancy to ensure their own health and the health of their unborn child. Readily available access to information regarding the effects of stress on pregnancy, ways to deal with stress, and available mental health resources are indicated (Anhalt, Telzrow, & Brown, 2007). Clinically, the use of assessment tools, psychoeducational tools, and support groups would emphasize the importance of maternal mental health and well-being. Feldman et al. (2000) suggest that supportive interventions may include the provision of educational information and emotional support by health care professionals and lay educators throughout the course of pregnancy.

Summary

Studies strongly indicate that stress creates adverse effects in pregnancy and therefore on the fetus. In the next chapter a review of current literature regarding stress during pregnancy will be presented. In addition, the benefits of group support in addressing the unique needs of expectant mothers will be discussed.

Chapter II

Review of the Literature

Review of current literature regarding stress has made a compelling case for an intervention program to combat maternal stress in pregnant women. First, the procedure for extracting the research for the literature review will be presented. Second, stress will be defined as a general construct and examined in its role during pregnancy. Third, the prevalence of stress during pregnancy and the measurement of stress during pregnancy will be presented. Fourth, research regarding outcomes of stress during pregnancy and perinatal and postnatal outcomes will be offered. Last, interventions for expectant mothers dealing with stress will be examined, including concepts of social support and pregnancy, sources of support and maternal stress, and group work.

Procedure

Research on pregnancy related group therapy is scarce. Information for the literature review was obtained from many sources including the World Wide Web, books, and online journal databases. All relevant studies were reviewed from 1967 to October 8, 2008. Major databases (PsychINFO, Ovid, ERIC, EBSCOhost and HAPI) were searched using (separately or in combination) the following key words: maternal*, antenatal*, stress*, pregnancy*, behavioural, cognitive, problems, fetus, infant, children, prevalence, group counselling*, group therapy* anxiety and depression. Not all articles from the searches were available online and many articles were excluded as they did not meet the relevancy criteria. The limits placed on the search were human, English language, and published within the past 40 years.

In conjunction with the online databases the Keyano College book catalogue was

used with the keywords: stress, group therapy, and pregnancy. The book search resulted in references that did not meet the relevancy criteria. Titles and abstracts of identified studies were assessed for relevance to the topic and hard copies of appropriate studies were downloaded for further evaluation. References from review papers and identified studies were assessed for additional articles.

Similarities between Stress, Anxiety, and Depression

Anxiety, depression, and stress share some similarities and some qualitative differences in the way they are experienced, differing only in that depression is a mood disorder. Conceptually, anxiety and stress are closely linked and some researchers have used anxiety and stress interchangeably. “Anxiety may be defined as the psychological consequence of exposure to real or imagined stress” (Ruiz & Avant, 2005, p. 346). Furthermore, depression is a common consequence of stress.

It is relevant to note that stress and depression are distinct constructs however, the physiological changes seen in the stress hormone systems in those who are under chronic stress are similar to those that are seen in depression (O’Brien et al., 2007).

Stress, anxiety and depression share common symptoms or manifestations including agitation, fatigue, insomnia, irritability, constant worry, poor concentration and decreased motivation, and depression (Reed & Reed, 2004). It is common to experience anxiety and depression in tandem and both anxiety and depression can develop as a result of stress.

For clarity purposes I acknowledge that stress, anxiety, and depression are different yet similar constructs. For the purposes of this project, these terms are used interchangeably throughout the literature review.

Stress

It is common to hear people express that they feel overwhelmed or stressed. At present, stress has been linked to disease and illness and may account for 70 to 80 percent of all disease and illness (Cormier & Nurius, 2003; Seaward, 2006). Stress related illnesses include autoimmune diseases (e.g. cancer), cardiovascular diseases (e.g. heart disease), and cerebrovascular diseases (e.g. stroke). According to Seaward, stress-related diseases cost the American health care system over \$400 billion a year and place the system in danger of collapsing. There is enough evidence for health care professionals to be concerned about stress that is expressed by patients and to make recommendations for stress reduction. Currently, health care reforms have concentrated on lifestyle changes and preventative measures.

Stress is the process that occurs when the body encounters environmental circumstances that disrupt, or threaten to disrupt, physical or psychological functioning (Pinel, 2000). Therefore, stress involves a transaction between people and their environments. Similarly, Ruiz and Avant (2005) stated that “stress is used to describe any physical or psychological challenge that threatens, or has the potential to threaten, the stability of the internal milieu of the organism” (p. 1).

Psychological stress is difficult to cope with and exists in response to four basic scenarios. According to Matchett (2004) psychological stress is experienced when:

- 1) we feel our beliefs, values or well being are threatened
- 2) we have to adjust to change
- 3) we have a sense of vulnerability and feel we are losing control

4) we have to cope with unrealized expectations.

The causative factors that require people to adjust to their environments are called stressors and stress reactions are the physical, psychological, and behavioural responses that people exhibit when faced with stressors. Stressors can include daily hassles, life changes, and catastrophic events. Studies have indicated that the small stressors in life (daily hassles) and life changes may be the most significant sources of stress (Seaward, 2006; Ruiz & Avant, 2005). If stress increases unchecked, the likelihood of illness becomes pronounced. People facing stress may feel depressed, worried, and anxious and these feelings can impede health related behaviours such as eating a balanced diet, exercising, and sleeping. People may also draw on negative coping strategies such as smoking, drinking and consuming illicit drugs. Risk factors in experiencing stress include poor social support, ineffective coping skills, and psychopathological conditions (Youngkin & Davis, 2004).

Stress and Culture

Every individual develops a particular worldview on life based on their ethnic identity, cultural background, and socioeconomic status. Culture and ethnicity influence how stress is experienced and each culture has culturally patterned responses to stressful life situations. The majority of research regarding stress and how it is experienced by different ethnic minorities is based heavily on Eurocentric beliefs (Smith, 1985). Research on the experience of stress in different cultures has been noticeably absent from the literature.

According to Cormier and Nurius (2003) cultural differences exist in the presentation and management of stress. For example, in Eastern philosophy stress is

referred to as the absence of inner peace while stress in western culture results from a loss of control (Seaward, 2006). The presentation of one form of stress in India is known as the *dhat* syndrome; where an individual experiences somatic symptoms and does not require the help of a professional. In Latin American countries stress is expressed as *nervios*, which is characterized by generalized anxiety in combination with principal symptoms (Cormier & Nurius).

The varying concepts of stress in different cultures illustrate the importance of understanding stress from each individual's cultural learning and contextual factors. Therefore, the holistic perspective of stress best captures the experience of stress among most cultural groups. From a holistic perspective, stress is the "inability to cope with a perceived (real or imagined) threat to one's mental, physical, emotional, and spiritual well being, which results in a series of physiological responses and adaptations" (Sarafino, 2006, p. 4). For the purposes of this project, stress will be defined as a situation where environmental demands exceed an individual's ability to cope effectively and result in negative consequences (Saunders, Driskell, Johnson, & Salas, 1996; Seaward, 2006).

Stress and Pregnancy

Pregnancy can be a time of great joy and anticipation, but for some expectant mothers' pregnancy can be a source of stress. During pregnancy some sources of stress might include limited social support, not feeling ready to become a mother, fear of parenting ability, pregnancy related physical discomforts (fatigue, nausea etc.), financial stress, fear of labour and delivery, worries about the baby's health, dealing with the

complications of a high risk pregnancy, severe life events during pregnancy, and relational changes in an intimate relationship.

In the past 60 years there have been a growing number of studies that have suggested that stress in pregnancy should be added to the list of prenatal risks affecting fetal and child development (Van den Bergh et al., 2005). Researchers have examined the effects of stress on pregnancy and have presented an exhaustive list of the harmful effects of maternal stress on perinatal outcomes (Davis & Sandman, 2006; Dayan, Creveuil, & Marks, 2006; King & Laplante, 2005; Lobel et al., 2000; O'Brien et al., 2007; O'Connor, et al., 2003). Harmful outcomes include preterm birth, low birth weight, heart disease, obesity, and diabetes in the infant when they become an adult.

The hormonal changes that occur as a result of the reproductive cycle can increase the risk for mental health issues in women. Pregnancy is a major life event coupled with hormonal changes is concomitant circumstances that can increase a woman's vulnerability to the onset or return of mental health issues such as depression (Bennet, Einarson, Taddio, Koren, & Einarson, 2004). Antenatal clinics can expect one in five pregnant women to be experiencing mental health issues (Hollins, 2007). Moreover, increased depressive and anxious symptomatology during pregnancy is a strong predictor of elevated anxiety and depression during the postpartum period (Brouwers, Baar, & Pop, 2001).

Frequency of Stress during Pregnancy

Results of numerous epidemiological studies suggest that stress levels during pregnancy are significant (Van den Bergh et al., 2005). Recent data indicates that as many as 20% of pregnant women met the criteria for depression (Anhalt, Telzrow, &

Brown, 2007; Hoffman & Hatch, 2000). Another research study cited a higher prevalence of depression in pregnant women and stated that as many as 30% of women suffer from some level of depression during pregnancy (O'Brien et al., 2007). Current data has indicated that the rates are even higher for women from low socioeconomic groups and that approximately 40% of pregnant women meet the clinical criteria for depression (Anhalt, Telzrow, & Brown; O'Brien et al., 2007). Furthermore, major depressive disorder occurs at twice the rate for women than men and depression is the leading cause of disease among women in their childbearing years (O'Brien et al. 2007).

Given the high rate of mental health problems during pregnancy, it appears only a small percentage of women actually receive treatment as illustrated in a recent study in which 26% of women screened positive for mental health illness, yet only 2% of these women were actually identified or referred for mental health services by their health care provider (Smith et al., 2004). A meagre 50% of obstetricians cite knowledge relevant to mental health issues and believe that it is part of their responsibilities. It appears that assessing mental health issues, during pregnancy is relevant but lacking and that women need improved access to mental healthcare during the course of pregnancy.

Assessing stress during pregnancy. In general, stress is difficult to operationalize because “psychological characteristics moderate both the appraisal and affective response to stressors” (DiPietro et al., 2002, p. 3). Despite the significant interest in the adverse effects of stress during pregnancy, few instruments are available to measure pregnancy-specific stressors (DiPietro, Ghera, Costigan, & Hawkins, 2004). Since pregnancy itself is a significant source of stress, there are pregnancy specific psychosocial features that complicate the measurement of stress. According to DiPietro et al. (2004) assessment

tools for measuring stress during pregnancy fall short in acknowledging pregnancy specific stressors. Moreover, research has typically focused on the distressing, negative aspects of pregnancy. Existing measurement tools (e.g. hassles scales) have used more general determinants of stress that are helpful in understanding pregnant women's experiences (DiPietro et al., 2004).

The diagnosis of depression during pregnancy is based on clinical signs and symptoms reported by the expectant mother on self report questionnaires and structured interviews (Bennet et al., 2004). Two instruments, the Edinburgh Postnatal Depression Inventory and the Beck Depression Inventory, have been used to determine the prevalence of depression during pregnancy. Both these instruments have been afforded as acceptable measures for depression during pregnancy (Bennet et al.).

Maternal Stress and Outcomes during Pregnancy

The effects of prenatal stress on perinatal outcomes in animal pregnancies have been studied extensively. According to this abundant research, exposure to stress during pregnancy can have profound and permanent influences on fetal growth and development. The hypothalamic pituitary adrenal axis (HPA) has been identified in animal research as the link between prenatal stress and distressed behaviour in animal offspring (Buitelaar et al., 2003; Van den Bergh et al., 2005). A similar hypothesis has been established in human mothers and infants yet there have been very few studies examining the function of the HPA axis during pregnancy (Van den Bergh et al., 2005). During pregnancy the psychological state of the mother is linked to hormonal changes. These changes include fluctuations in the stress hormones of the HPA including the stress hormone cortisol. Ruiz and Avant (2005) have stated that a pregnant mother's response to

stress causes an elevation in stress hormones. Increases in these hormones suppress the mother's immune system which predisposes the mother to illness.

For the developing fetus there is biological support for the “significant association between daily hassles and increased hormone levels (e.g. salivary cortisol levels), which were independently associated with lower mental and psychomotor development” (DiPietro et al., 2002, p. 2). This research suggests that mothers who experience high levels of anxiety during pregnancy may expose their babies, in utero, to increased levels of stress hormones. Additionally, stress affects the fetus when stress hormones (e.g. cortisol) are released into the mother's bloodstream and cross the placenta, resulting in increased fetal heart rate and activity level (Berk, 1998; Brouwers et al., 2001; DiPietro et al., 2002). Chronic maternal stress (e.g. daily hassles) has been linked to adverse effects on the developing fetus (Anhalt, Telzrow, & Brown, 2007; DiPietro et al., 2002; King & Laplante, 2005; Lobel, et al., 2000; Ruiz & Avant, 2005). Van den Bergh et al. (2005) stated that exposure to cortisol is essential for healthy brain development, but in excess it has long term effects on neuroendocrine functioning and behaviour.

Maternal anxiety during pregnancy has also been linked to altered blood flow to the fetus (O'Connor et al., 2003). According to Berk (1998), stress during pregnancy can affect the developing fetus when parts of the body require additional blood for the brain and heart thereby, reducing blood to organs such as the uterus and resulting in the fetus receiving less oxygen and nutrients.

According to research, there are two possible reasons that chronic stress has a negative impact on the fetus. First, the physical and emotional environment of the pregnant mother is unlikely to change over the course of pregnancy and there may be a

cumulative effect because the stress state of the mother is unchanging. Second, chronic stress may be the result of a woman's outlook on life and her tendency to view her life as stressful (Lobel et al., 2000). This has a direct impact on the fetus because the stress hormones are remaining constant in the mother. In addition to the two reasons that research has shown, other research shows that these other reasons also contribute to a negative impact on the fetus. As well women experiencing stress during pregnancy may engage in negative coping mechanisms that may harm the fetus. Women who are depressed during pregnancy may draw on negative coping mechanisms and are more likely to abuse alcohol and drugs and are also at risk for suicidal ideation (O'Brien et al., 2007). Van den Bergh et al. (2005) state that preterm delivery and low birth weight are the most researched areas on subject of maternal stress during pregnancy and its effects on the baby after birth.

Maternal Stress and Outcomes after Pregnancy

Low birth weight and prematurity have been associated with an increased risk of infant mortality and impaired psychological development (Istvan, 1986). Preterm birth has been linked to prenatal stress in several studies (Davis & Sandman, 2006; King & Laplante, 2005). Dayan, Creveuil, and Marks (2006) conducted a prospective cohort study with pregnant women living in France with the intent to investigate prenatal anxiety and depression and preterm birth. Their study concluded that women with higher depression scores had a higher rate of preterm birth than those women that did not have depression.

According to Berk (1998), severe anxiety has also been associated with lower birth weight, higher rates of miscarriage, and newborn respiratory illness. In one study by

Lobel et al. (2000) women who were least optimistic during pregnancy delivered babies with lower birth weight. This statistic is significant because babies with low birth weight are 65 times more likely to die while surviving low birth weight children have higher rates of subnormal growth and illness (Lobel et al., 2000). Lower birth weight has been linked to many health related risks including coronary heart disease, hypertension, obesity, and type 2 diabetes later in life (Gutteling, Weerth, Willemsen-Swinkels, Huizink, Mulder, Visser, & Buitelaar, 2005; Van den Bergh et al., 2005).

Additional perinatal outcomes. Maternal depression during pregnancy has been linked to poorer scores on the Brazelton Neonatal Assessment Scale (e.g. habituation, orientation, and autonomic stability) lower vagal tone, EEG activation, elevated cortisol and norepinephrine levels, lower dopamine and lower serotonin levels (Davis, Snidman, Wadwa, Glynn, Schetter, & Sandman, 2004; Van den Berg et al., 2005), smaller head circumference (Buitelaar et al., 2003), lower fetal motility (Brouwers et al., 2001) in the newborn, and higher admissions to neonatal intensive care units (Lobel et al., 2000). Consequently, maternal depressive symptoms may be on a continuum of child development, where depressive symptoms during pregnancy may lead to an irritable newborn, which then adds to the mother's depressive feelings (Zuckerman, Bauchner, Parker & Cabral, 1990). As mentioned earlier, the physiological changes seen in the stress hormone systems in people under chronic stress are similar to those that are seen in depression, therefore, the aforementioned studies further reinforce the effects of maternal mood on the developing fetus.

These studies indicate the adverse effects of maternal stress on perinatal outcomes. Consequently the reported adverse effects on infants have been linked to a

developmental continuum from prenatal life through childhood and into adult life including obesity, heart disease, and diabetes. Addressing the mental health needs of pregnant women may reduce these multiple risk factors, and improve quality of life for both infants and their mothers.

Prenatal Stress and Long Term Outcomes on Infants and Children

There is a growing body of research that link prenatal psychological health problems to a continuum of effects seen in infants and children. There are studies that indicate a relationship between the psychological stress experienced by the mother and its resulting biological response, and outcomes on the neuroendocrine and immune systems of the developing infant (Ruiz & Avant, 2005). These effects relate to infant temperament and attachment, growth and sleep patterns, motor and development of toddlers, emotional and behavioural regulation problems in children.

Infant temperament and attachment. Prospective studies on the influence of maternal stress on infant temperament are sparse; however, there are several recent studies that have reported that maternal stress during pregnancy shapes infant behaviour, temperament and attachment patterns (Buitelaar et al., 2003; DiPietro et al., 2002).

In a study that researched the effects of prenatal maternal stress on infant development stress during pregnancy was related with difficult temperament in infants (Vander Bergh, as cited by O'Connor et al., 2003). Similarly, Buitelaar et al. (2003) showed a significant association between maternal stress during pregnancy and infant temperament. These researchers found that mothers with stress had infants that had adaptation problems to new situations and unfamiliar people. DiPietro, Hodgson, Costigan & Johnson (1996) found that stress during pregnancy may lead to reduced fetal

heart rate variability which may be linked to temperamental inhibition in childhood.

Buitelaar et al. (2003) found that various aspects of prenatal maternal stress had a negative outcome on the temperament of infants at 3 and 8 months of age. Infants in this study had problems coping with novel situations, difficulties in attention regulation, and goal directedness. Stress during pregnancy has been reported to be linked to maternal readings of negative infant temperament in 6 month old infants (Niederhofer & Reiter, 2000). Gutteling et al. (2005) carried out a prospective study in which the researchers examined the influence of prenatal stress in infant temperament. The results of the study indicated that children of mothers who reported more fear of bearing a handicapped child had an increased chance of being in the restless/disruptive temperament group. This was in comparison to mothers who reported less fear of bearing a handicapped child.

Van der Wal, Van Eijnden, and Bonsel (2007), conducted a large prospective study with a sample of 4976 women with 3-6 month old babies. The researchers established an association between stress and emotional problems during pregnancy and excessive infant crying. Similarly, Brouwers et al. (2001) have stated that infants of mothers with high levels of stress during pregnancy have been found to cry more and change emotional states more frequently than those that had non-stressed mothers.

Infant growth and sleep patterns. Research has indicated that newborns are more irritable and less consolable when prenatal depression was present in the mother. Furthermore, infants that were exposed to maternal depression in utero also showed signs of impaired growth and decreased alertness (Brouwers et al., 2001; DiPietro et al., 2002). Buitelaar et al. (2003) found that prenatal stress predicted the mental and motor development of infants. These researchers reported that pregnancy specific anxiety was

correlated to lower scores on the Bayley Scales of Infant Development (BSID). The BSID is a scale used to assess the mental, behavioural, and motor skills of an infant. In a study carried out by Smith, Wills, and Naylor (as cited by Ruiz and Avant, 2005), mothers who experienced anxiety during pregnancy, had infants that spent less time in quiet and active alert states, and showed lower motor organization and autonomic stability.

The results of these studies indicate that infants of mothers with prenatal anxiety, stress, and depression are found to be more unsettled in their behaviour (e.g. fussing and crying) and have a higher rate of sleep disturbances (e.g. less time in deep sleep and more time in disorganized sleep). Recent studies have established a relationship between prenatal stress and developmental, emotional, and behavioural problems in children (Brouwers et al., 2001; King & Laplante, 2005).

Motor and mental development of toddlers. Several studies have indicated that maternal prenatal stress can have a negative effect on cognitive and language development in toddlers. Brouwers et al. (2001) have established that high maternal anxiety during pregnancy is linked to delays in mental development and attentional processes in 2 year old children. These researchers concluded that prenatal anxiety predicts lower mental development in children including delayed language development and lowered intellectual functioning. Similarly King and Laplante (2005) conducted a prospective study in which they examined 150 children who were exposed to a natural disaster in utero. The researchers found that moderate-high prenatal stress was associated with poorer language functioning at age 2. These children spoke, on average, 20 fewer words which represented a 30% reduction in productive vocabulary. The results of this

study also established that children who were exposed to moderate-high stress in utero engaged in significantly more stereotypical play and less functional play than their low stress counterparts. The researchers concluded that the intellectual abilities of children were affected as indicated in lower Bayley MDI scores.

Emotional and behavioural regulation problems in children. Several studies have suggested a persistent effect from prenatal stress which starts in utero and lasts into childhood. O' Connor et al. (2003), have found that children born to mothers who experienced high levels of anxiety in pregnancy showed higher rates of behavioural and emotional problems. Findings from this study also established a connection between prenatal maternal anxiety and increased risks for conduct problems, symptoms of hyperactivity and inattention, and emotional problems in children at four years of age.

Gutteling et al. (2005) found that prenatal anxiety predicts problem behaviour in children with a continuum of effects into later childhood. Similarly, Bergman, Sarkar, O'Connor, Modi, and Glover (2007) found prenatal stress to account for 17% of the variance in cognitive ability in children 14-19 months of age.

Anhalt et al. (2007) conducted a study that examined 948 mother-child dyads using hierarchical multiple regression. The children were first examined in the perinatal period and again in the first grade. The findings of the study suggested that maternal stress, anxiety, and depression altered offspring neurological development. Neurodevelopmental affects included increased attention-deficit/hyperactivity disorder symptoms, anxiety, and an increased risk of childhood depression.

Stress, anxiety and depression may exist before pregnancy, and may be exacerbated by pregnancy and mothering. The results of these studies suggest a

transactional model in which the relationship between infant temperament and maternal stress is on a continuum. Stress before and during pregnancy, may lead to temperamental difficulties in the newborn, which may lead a mother to feel additional stress after delivery. Therefore, suggesting that the stress during pregnancy exerts a programming effect on the fetus with consequences for later infant and childhood development.

Role of Social Support in Pregnancy

Social relationships are an important aspect of everyday life and influence health and well-being in all stages of life (Sarafino, 2006; Feldman, Dunkel-Schetter, Sandman, & Wadwa, 2000). Everyday life events require people to constantly regulate emotional, mental, and environmental demands and seeking the help of others usually becomes a necessity. The level of social support one has in their social network is directly linked to psychological well-being (Collins et al., 1993). Social support is helpful for many reasons. It gives us: a sense of meaning and belonging, increased positive affect, an enhanced sense of self esteem, a feeling of self efficacy, and it reduces the extent to which life circumstances are appraised as stressful.

Although pregnancy is a time of joy it can also be a source of psychological and physical stress. “Supportive relationships may enhance feeling of well-being, personal control, and positive affect, thereby helping women to perceive pregnancy-related changes as less stressful” (Collins, et al., 1993, p. 1245).

Sarafino has stated that social support serves as an environmental mediator and has a helpful effect on stress and coping; therefore, social support can be presumed to have a positive effect on the health of expectant mothers. Women with lower levels of

social support during pregnancy increase the physical, mental and emotional risks to themselves and their unborn child (Anhalt et al., 2007).

Cohen has stated that “a woman’s capacity to adapt to the demands and tasks of pregnancy is generally related to an overall balance between stresses and supports, both present and past” (as cited by Brown, 1986, p.72). According to a study conducted by Collins et al. (1993), expectant mothers experiencing stress during pregnancy who accessed social support delivered babies of higher birth weight. The study also concluded that the mothers that received social support experienced less postpartum depression.

Sources of Support

There are a number of professional and non professional sources of support that women can access during the course of pregnancy. An expectant mother can find support in different ways. Most women will access support through family and friends. Some women may turn to support groups in their communities and online and others may access the care of paid caregivers.

Non professional sources of support. Family and friends are significant sources of support for some expectant mothers and this type of support is an important resource for women to help them cope with stress. Expectant mothers can talk about their stress with other expectant and experienced mothers on the internet. Through this medium expectant mothers have access to one another’s stories and ideas about pregnancy and mothering. The internet can offer support via pregnancy related message boards and mailing lists. BabyCenter.com, Pregnancy.org, and Babycenter.ca are several pregnancy related websites that offer this type of support.

Professional sources of support. Certified midwives and direct-entry midwives are also sources of education and support for pregnant women (The Boston Women's Health Book Collective, 2008). Midwives are trained to provide emotional, mental and physical support during prenatal visits and during labor and birth. Birth assistants such as doulas are also trained to support women during pregnancy and labor. They are also able to provide support after delivery and this may include caring for other children and cooking. The role of these caregivers is to provide nurturing and care to the expectant mother.

Family Physicians and Obstetrician-Gynaecologists (ob-gyns) can also provide comprehensive care to pregnant women. One of the advantages of an expectant mother seeing a family doctor through her pregnancy is that they have knowledge of the entire family and this can increase the care the expectant mother receives (The Boston Women's Health Book Collective, 2008).

Mental health agencies also provide maternity care and offer counselling in an individual and group setting. Mental health professionals include psychologists, social workers, and other therapists. These professionals can provide support to expectant mothers through the use of talk therapy. It is important to mention that most of the mental health services that are available are accessed by women once they have become mothers and are experiencing depression and anxiety (postpartum). Several recent books on pregnancy contain little to no reference to prenatal stress and stress management (Gaudet, 2007; Reed & Reed, 2004; Evans & Aronson, 2005).

Maternal Stress and Group Work

Research on pregnancy related group therapy could not be found within the parameters listed in the procedures section of this paper. However, Corey and Corey (2006) stated that group therapy is as effective as individual therapy for the treatment of psychological problems suggesting that psychoeducational groups for managing stress are useful. They also stated that “group therapy provides a natural laboratory that demonstrates to people that they are not alone and that there is hope for creating a different life” (p.5). The social environment of the group is a catalyst to hope, interpersonal learning and universality.

Social support has been established as a mediator between stress and healthy pregnancy (Anhalt et al., 2007). Furthermore, Feldman et al. (2000) stated:

During pregnancy, social support is considered essential to the health and well-being of the expectant mother. The provision of emotional, informational, and material resources may mitigate the physical and psychological strains associated with pregnancy. (p. 715)

Summary

The preceding literature review is part of a growing body of research that links prenatal psychological health problems to a continuum of effects seen in infants and children. It is important to mention that a few stressful days during the course of pregnancy will not damage a baby’s development. Most of the problems are seen in cases where severe stress was experienced by an expectant mother (such as what might be experienced by a woman in an abusive relationship). The research strongly indicates a link between a mother’s emotional state, her health and the environment. There is also a

continuum effect between the mother's emotional environment (stress) and the baby's health.

The findings in the literature review regarding the adverse effects of stress during pregnancy and the buffering effect of social support provide a compelling case for the creation of a psychoeducational group program for expectant mothers. Group counselling is critical in the field of counselling and the Happy Moms and Happy Babes Group Program was developed with relevant information regarding current group counselling research, group techniques, and group interventions. Results of many studies have indicated that stress during pregnancy is significantly high; therefore, the need for a proposal that focuses on the specific needs of expectant mothers was developed. These results have motivated me to develop a program that caters to the needs of expectant mothers. Supportive interventions including group counselling, the provision of educational information, and emotional support by health care professionals and lay educators throughout the course of pregnancy have been addressed in this group proposal.

There is minimal academic research on the efficacy of psychoeducational counselling groups for expectant mothers; however, research indicates that group support for non pregnant individuals experiencing stress is useful. Through group participation the expectant mothers recognize that they are not alone and they ultimately gain validation for their experiences and reduce their stress. According to Horne, personal empowerment and systematic change are the major strengths of women's groups with the common denominator of supporting the experience of women (Corey & Corey, 2006).

This proposal contains a psychoeducational component and an interpersonal, process-oriented dimension. The following chapter contains group goals and objectives for the Happy Moms and Happy Babes psychoeducational group. Information on the structure and organization of the group and ethical issues in group work will also be explored.

Chapter III

Group Goals and Objective

The goal of the Happy Moms and Happy Babes group program is to provide social support for expectant mothers. Diverse in its composition, the common denominator among participants will be the experience of being a pregnant woman. In addition to the benefits gained from this shared understanding of pregnancy this program will provide tools to help the expectant mother assess her level of stress, education regarding stress and pregnancy, and practice in stress management techniques. These benefits are magnified in the supportive group setting and promote the ultimate purpose of decreasing isolation among pregnant women through shared experience. The profound strength of this program comes from this collective wisdom. Long- and short-term goals for achieving this ultimate objective are outlined in Table 1.

Table 1

Goals and Objectives of the Happy Moms and Happy Babes Group Program

Long-Term Group Goals	Short-Term Group Goals	Related Objectives	Session Theme(s) to Address The Goal & Corresponding Objectives	Measurement of the Goal & Corresponding Objectives
1. Social Support and the Nature of Stress	<p>Gain an understanding of what stress is</p> <p>Understand sources of stress</p> <p>Learn ways to decrease maternal stress</p> <p>Stress and Disease</p> <p>Social Support and validation of experience</p> <p>Culture and motherhood</p>	<p>a. Provide personal definition of stress</p> <p>b. Symptoms checklist</p> <p>c. Complete self- assessment “Are you stressed” (Craze, 2003)</p>	Session 1 –2, Stress and Illness & Building Supportive Relationships	<p>i. List stressors with a partner</p> <p>ii. Share with group</p> <p>iii. To gain 5 points toward wellness on the post-test</p>
2. Thought Awareness	<p>Create connection with others</p> <p>Understand how thoughts are linked to feelings and behaviours</p> <p>Use group to facilitate behaviour change</p> <p>Help mothers to transfer new skills and</p>	<p>a. Identify thoughts, feelings and physical reactions related to stressful situations</p> <p>b. Assess distressing thoughts</p> <p>c. Counteract distressing thoughts</p>	Session 3, Coping Strategies	<p>i. Self Monitoring Log</p> <p>ii. Ongoing monitoring- decrease subjective stress levels by 50% between session 4 and session 6</p> <p>iii. Ongoing discussion in group</p>

	behaviour to everyday life			iv. Homework
3. Assertiveness	Evaluate current patterns of communication Differentiate between aggressive, passive, and assertive styles of communication	a. Personal Bill of Rights b. Practice assertiveness (identify situations and role play)	Session 4, Communication Patterns and Stress	i. Share with group ii. Express feelings and opinions, set limits, and initiate change
4. Relaxation	Purpose of relaxation in everyday life Process of stress management Barriers to alleviating stress	a. Distinguish between tense and relaxed muscles Progressive Muscle Relaxation	Session 5, Relaxation	i. Behavioural rehearsal
5. Transitions and Saying Goodbye	Examine learning from previous five sessions Celebrate changes as it relates to the experience of stress and stress management	a. Seven techniques of managing stress	Session 6, Transitions	i. Share with group

Group Membership

The Happy Moms and Happy Babes Group Program is designed to remediate stress. The purpose of the group is to teach the expectant mothers symptomatic relief, problem solving strategies, and interpersonal skills that will accelerate personal change. Membership in the program will be determined as suggested by Yalom by a process of deselection in which group therapists exclude members and include others. Participation in the group would require the potential members to be at least 18 years of age and pregnant. Group participation will be voluntary and indicated when the pregnant woman presents with stress as marked by any of the following symptoms: negative affect, minimal social support, dependency, fear of assertiveness, and general distress. Stress will be measured with the DASS-21 (Depression Anxiety Stress Scales) during the screening process. Group Members must speak English and provide informed consent before participating in the group.

Marketing the Group

This program will be offered to expectant mothers. To recruit members the marketing posters will be distributed to local health care providers including the following:

- a) Obstetricians/Gynaecologists
- b) General Practitioners providing obstetrics
- c) Walk in clinics
- d) Hospital-Mental Health
- e) College health centre
- f) Local counselling agencies

g) Social Services (social workers)

h) Multicultural Society

i) Local churches, mosques and temples (with the permission of the clergy)

Group Screening

Prospective group members will be screened individually in the presence of both leaders and selected for the group based on the screening. During the screening interview the group leaders will provide prospective group members with information about group norms, group purpose, and expectations (Schulz, n.d.). Additionally, each member needs to take responsibility for her role in understanding and alleviating her stress. Motivation to change will be assessed as indicated by a willingness to participate in group process and activities (Prochaska, DiClemente, & Norcross, 1992). To assess motivation potential members are required to answer the following questions:

a) What am I willing to contribute to my own learning?

b) What am I willing to contribute so that others may learn in the group?

c) How positive is my attitude?

d) What would make me feel successful as I participate in this group?

The decision to select group members is made by both leaders. Potential group members will also be asked to sign a consent form at the screening interview (Appendix D). During the screening interview the leaders will also stress the importance of confidentiality. Individuals who are deemed inappropriate for the group will be informed and provided with information regarding other resources they can access based on individual needs. Referrals for those deemed inappropriate for the group will be offered an opportunity to discuss the reasons for not being accepted into the group. Potential

reasons would include (a) are not able to commit for the full duration of the program, (b) are experiencing severe psychological and behavioural disorders that require individual counselling (Yalom, 1985), (c) do not meet the age requirements, or (d) are aggressive, hostile, or self-centered (Corey & Corey, 2006).

Assessments

Depression anxiety stress scale (DASS-21). Stress will be measured with the DASS-21 during the screening process and through the course of the group program. The DASS-21 is a 21-item self report measure of depression, stress, and anxiety. The scale consists of three 7-item self report scales taken from the full version of the DASS. The results of a study conducted by Henry and Crawford (2005) concluded that the reliability of the DASS-21 scales is high. The DASS-21 has also been shown to possess adequate construct validity. Furthermore, the short length of the scale is advantageous for rapid assessment (Henry and Crawford, 2005). The diagnosis of stress during pregnancy is based on signs and symptoms reported by the pregnant mother (Bennett et al., 2004). The DASS-21 will capture the signs and symptoms the mom-to-be is experiencing. For the purpose of this group the short version of the DASS-21 will be used (Antony, Bieling, Cox, Enns, & Swinson, 1998). The DASS questionnaire forms may be downloaded and copied by the leaders, without restriction from the following website:

<http://www2.psy.unsw.edu.au/groups/dass/>.

Assessment of client progress (weekly). The assessment of client progress (weekly) is adapted from the Group Counseling Helpful Impacts Scale (Kivlighan, Multon, & Brossart (1996). This assessment is an informal method of assessing the expectant mother's progress after each of the six sessions. Weekly evaluations will be

given to the members to track current feelings, progress, and issues (Individual member outcomes – Please refer to Appendix A). The weekly evaluations will be provided to the group members at the end of each session.

Evaluation of group experience. The assessment of client progress is adapted from the Interpersonal Relations Scale Checklist (Kivlighan, Jaquet, Hardie, Francis & Hershberger, 1993). This assessment is an informal method of assessing the expectant mother's progress evaluation of group experience from the initial group meeting to the end of the last group meeting. According to Corey and Corey (2006) evaluation is a basic component of any group experience and has benefits for both the group members and the group leaders. "Standardized instruments can tap individual changes in attitudes and values" (p. 279). Evaluations can be beneficial for the group leaders because they provide information that can aid the group leaders in assessing what interventions were more, or less useful. This form is located in Appendix B of the group leader's manual.

Structure and Organization of the Group

The degree of structuring for a group is best decided by the group leader and exists on a continuum (Corey & Corey, 2006). In the initial stages of the Healthy Moms and Healthy Babes Group Program the leaders will be expected to provide enough structure to give a general direction to the group. Both leaders will encourage members to increase their individual responsibility as the sessions proceed. The following sections explore some general guidelines for the proposed group.

Program length. The Happy Moms and Happy Babes Group Program is a six-week psychoeducational counselling program comprised of 6 weekly group sessions. The

sessions will be two hours in length. The screening interviews would be scheduled 2 to 3 weeks prior to the first group session.

Location and set up. For the purposes of this group a community agency is preferred and one that is centrally located, in close proximity to public transit, and accessible to the disabled. The group will be conducted in a circle (symbolic of unity) with each member being able to see one another. Each leader sits across from the other and within the group to observe the nonverbal language of the group members (Corey & Corey). The room setup will include culturally relevant materials (e.g., pictures of moms from around the world).

Group characteristics. Participants of the Happy Moms and Happy Babes Group Program are expectant mothers at least 18 years of age. This group is targeted towards pregnant women experiencing stress; therefore, the group composition is specific to a target population with given needs (pregnancy and stress). Corey and Corey (2006) have stated that homogenous groups can lead to increased cohesion because members are interacting with others that share experiential similarities. All women attending the group will attend voluntarily and they may have been referred by other community health care professionals (e.g. obstetrician, individual counselling). All members are present with stress during pregnancy as marked by negative affect, mood, and general distress. Members are expected to remain in the group until it ends. Based on the research the minimum number of members is 6 and the maximum is 8. Corey and Corey stated that a group of this size is optimal since group members are able to interact and feel a sense of group cohesion. To address diversity in education and learning styles, a number of formats and sources of information will be available (pamphlets/books-visual learning,

DVD presentation of material-visual and auditory learning, and hands on group exercises-hands on learning).

Member expectations. Group leaders will provide the group members with a handout that outlines the expectations for the Happy Moms and Happy Babes Group Program at the screening interview. The group leaders will facilitate a discussion about the following expectations (Chen & Rybak, 2004):

- Members are expected to attend all scheduled sessions and to arrive on time for each session.
- Members are expected to actively participate in the program and to cooperate in the evaluation (relating to current feelings and ongoing progress made in the program) of the services they receive (Appendix B).
- Members are expected to listen to and respect others from a non-judgmental perspective. Members will work toward helping each other so that everyone in the group has a safe and cohesive place to achieve their personal goals.
- Members will work towards helping each other and creating a safe place for others to express themselves.
- Members are expected to respect confidentiality; whatever is said or done in the group is not to be talked about outside of the group. This is imperative in developing group trust and cohesion. Group leaders will facilitate a discussion about the definition of confidentiality and how each group member is responsible. During this discussion, group leaders will also outline the limitations of confidentiality for ethical reasons

The discussion of these points will explain that meeting these expectations will create a more productive experience for all group members.

Group process notes. All documentation for group members will be completed by group leaders at the end of each session and will consist of individual progress towards goals and participation in the group. Any contact between a group member and a group facilitator (e.g. phone conversation regarding inability to attend group), outside of regular session time, will be documented. Please refer to Appendix C for group process notes that have been adapted from Wiger's clinical documentation sourcebook (1999).

Group leaders. For ethical reasons group leaders must only facilitate groups that they are trained and experienced for (Corey & Corey, 2006). According to Corey and Corey "various professions have differing training and educational standards for group work..." (p. 85). Because of the inconsistency of training there is no regulated set of qualifications established for all group leaders. But, there are general areas of professional experience that are considered basic for any group facilitation. For the purposes of the Happy Moms and Happy Babes Group Program two leaders would be ideal for a group of 6-8 women. The gender of the leaders could be male or female but, because of the personal nature of the group, at least one of the leaders must be a female. The group leaders would need to have some training for psychoeducational groups and this may include a course in theory and practice of group counselling (Corey & Corey, 2006). One of the group leaders must have an approved Master's degree in counselling, social work, or psychology with course work and/or experience in areas of health psychology and group processes. Content knowledge in stress management and healthy lifestyles is an additional asset.

Supervision. After each session, facilitators will meet for peer supervision and debriefing time. Group members will be informed of co-leader peer supervision at the screening interview. Corey and Corey (2006) stated that peer supervision is very beneficial for objective feedback. If resources permit, group leaders are encouraged to obtain additional intensive supervision by a competent group therapist (Corey & Corey, 2006).

Preparation and debriefing time. Both leaders will equally share the responsibility of forming the group and getting it started. Preparation of each weekly session should include the leaders arranging to meet for an hour time period, prior to the weekly session, to discuss group objectives and group progress and to prepare material for each session. Additional responsibilities during these meetings will include joint participation in (Corey & Corey, 2006):

- recruiting members
- conducting screening interviews
- agreeing on ground rules, policies and, procedures
- preparing group members for each session
- helping group members understand the group process as it unfolds
- discussion around practical matters of running a group (e.g. documentation)
- creating opportunities for group leaders to work together cohesively
- sharing their theoretical orientations, leadership styles, and prior group experience with one another and sharing any reservations regarding co-leading

Respecting cultural diversity. Group leaders must be conscious of and sensitive to the cultural diversity that exists in society (Corey & Corey, 2006). “Some of the group norms generally associated with group participation may not be congruent with the cultural norms of some clients” (p. 79). Furthermore, the issues that members bring forth to the group are affected by culture and members may or may not want to work on these issues (Chen & Rybak, 2004, p.82; Corey & Corey, 2006). Group leaders must be willing to determine what behaviours group members are willing to share with the group and at the same time be willing to understand how their cultural, religious, racial, and ethnic identity impacts his/her beliefs about the counselling process.

Cultural diversity will be respected in the Happy Moms and Happy Babes Group Program in the following ways (Corey & Corey, 2006) Group leaders will:

- acknowledge how ethnicity and culture influence behaviours
- examine how social, environmental, and political factors impact the issues that group members experience
- acknowledge their responsibility to acquire knowledge and skills necessary to work with diverse group members

Cultural diversity may be addressed through discussion in the second session and both leaders will share their own answers with the group. DeLucia-Waack and Donigian have suggested that a group leader who clarifies personal values and beliefs is taking steps in becoming multiculturally competent (as cited by Corey & Corey, 2006). Some questions that each member and group leader would be requested to answer would be:

- Can you share something with the group that is unique about yourself? How do you identify your race or ethnicity? (Corey & Corey, 2006)
- What does the word family mean to you?
- What family/parenting values are most important to you?
- Where did you learn these values?
- What does the word mother mean to you and how is that linked to your culture/ethnicity?

Finally a short video clip of mothers around the world will be shared with the group (e.g. “Moms around the world: Earth’s mothers”- Oprah Winfrey).

<http://boutique.oprah.com/product/show/5911>

Ethical Issues in Group Work

Corey and Corey (2006) stated that it is unethical to conduct groups without appropriate training. Therefore group leaders will maintain competence as a facilitator through professional development (AGPA, 2008). Group leaders will adhere to the American Group Psychotherapy Association (AGPA, 2002) and *The Canadian Code of Ethics for Psychologists* (CPA, 2000) to support and guide ethical work. In addition to following the Code of Ethics the group leader will also share his/her qualifications with the group members at the onset of the group. Both leaders must have a strong understanding of issues with diversity and strive to be diversity competent group leaders.

In a community it is possible that members will be culturally diverse; therefore, leaders need to clarify what needs they can and cannot meet within the group (Corey & Corey, 2006). In working with culturally diverse groups it is paramount not to make assumptions about race, ethnicity, or culture without confirming the assumptions with

potential group members (Corey & Corey). Leaders need to avoid imposing their cultural beliefs onto group members. Group leaders should have a reasonable understanding of their own cultural conditioning and be aware of their potential biases, stereotypes, and prejudices. Finally, leaders need to monitor their work through ongoing consultation, education, and supervision. In addition to the ethical guidelines that apply to individual counselling there are additional components to group work including confidentiality, informed consent, and risks for potential members. In order to protect the group, as well as the group leader, the group leader will state that they are not a supervisor, teacher, or evaluator. They will assert that they cannot give legal, medical, financial or any other type of advice.

Confidentiality. One of the major conditions for effective group work is confidentiality (Corey & Corey, 2006). At the onset of the group, the leaders will clearly address the need for confidentiality and repeat this guideline or rule at the beginning of every session. Before the group is initiated the leaders will explain the legal limits and exceptions to confidentiality (written permission given by a group member, threat to self or others, suicidal ideation, courts mandate records, when the leader must consult with others, and child abuse or neglect). Throughout the course of group work the leaders will emphasize the seriousness of the confidentiality process. “Group leaders must express the importance of maintaining confidentiality, and may consider having members sign contracts agreeing to it and even impose some form of sanction on those who break it” (Corey & Corey, 2006, p. 72). Leaders will express to group members that they can only guarantee their individual confidentiality and not on the part of other group members (AGPA, 2002; Corey & Corey, 2006; Schulz, n.d.). Group leaders will also discuss

requirements of ongoing clinical documentation. Confidentiality and exceptions to confidentiality will be provided on the informed consent form (see Appendix E).

Informed consent. It is ethical practice to provide a professional disclosure statement, , that includes information on the nature of the group, confidentiality parameters, leader's theoretical orientation, the roles and responsibilities of group leaders and members, and the qualifications of the leader, to potential group members (Corey & Corey, 2006). In order to participate in the Happy Moms and Happy Babes Group Program all potential group members are expected to determine whether the group is appropriate for them and then sign the consent form (see Appendix D).

During the first session the leaders will discuss the policies pertaining to attendance, number of sessions, and leaving a session if they are feeling uncomfortable (Corey & Corey, 2006). It is the group leaders' responsibility to inform potential members about the nature of the group and commitment to the group for carrying out member responsibilities.

Psychological risks of group counselling will be discussed during the first group session. Group leaders will also discuss the nature of group work and the constructive nature of taking risks in group work (Corey & Corey, 2006). Prospective members will also be provided with information on potential risks of participating in a group program. Potential risks may include scapegoating, group pressure, breaches of confidentiality, and aggressive confrontation (Corey & Corey, 2006). Information about the risks of group counselling will also be included on the informed consent form (see Appendix D). Member responsibilities and rights for attaining the maximum benefit from the Happy Moms and Happy Babes Group Program will be discussed with program participants

(Corey & Corey, 2006) and provided in written form (included in the program manual as a Pre-Group Meeting handout).

Summary

Current research recommends early preventative mental health care through public health models that focus on pregnant women (Anhalt et al., 2007). A preventative psychoeducational group that focuses on stress during pregnancy is proposed given the high rate of mental illness during pregnancy. This proposal has many strengths and limitations but addresses the special needs of expectant mothers and provides them with the opportunity to work together on common issues such as stress, increasing social support, and relaxation techniques. It is this author's intention that the group program will help expectant mothers access the emotional care they need during their pregnancy.

Chapter IV

Conclusions

Maternal mood during pregnancy has persistent effects on the experience of expectant mothers and on the developmental health of human babies (Davis, Snidman, Wadwa, Glynn, Schetter, & Sandman, 2004; Buitelaar, Huizink, Mulder, Medina & Visser, 2003; DiPietro et al., 2002). The Happy Moms and Happy Babes Group Program was developed with careful consideration of the most relevant research regarding prenatal stress and the implications stress has on the developmental health of human babies in utero and beyond. The following provides an overview of the strengths, limitations, and implications for practice and research as it relates to developing a psychoeducational group program for expectant mothers.

Strengths of the Proposal

The Happy Moms and Happy Babes Group Program is intended to provide expectant mothers with social support in the context of group counselling. The social environment of the group is anticipated to provide expectant mothers with the installation of hope, the imparting of information, interpersonal learning, and a feeling of universality in their experiences. In addition, psychoeducational materials regarding the effects of stress and healthy ways to cope with stress are also a part of the program. Given the negative impacts stress may have on expectant mothers, and babies in utero, assessing prenatal stress represents a significant commitment to valuing the physical and mental health of children and families. However, current prenatal mental health assessments don't exist or are utilized without appropriate follow-up or treatment options. "At present, there is a paucity of pregnancy-specific tools that can be used for clinical screening"

(Ruiz & Avant, 2005, p. 349). The majority of pregnancy related mental health assessments cater towards post-natal care. Overall, emotional, informational, and material resources may help reduce the physical and psychological stresses related to pregnancy.

There is ample evidence to warrant prevention, intervention and support programs to assess and reduce stress during pregnancy (Van den Berg et al., 2005). The Happy Moms and Happy Babes Group Program will help expectant mothers assess their maternal health, access social support, and become better informed about the implications of stress during pregnancy.

Limitations of the Proposal

Limited research is available to support interventions that counter the adverse effects of stress on expectant mothers' and their babies. Research on pregnancy related group therapy could not be found within the parameters listed in the literature review section; therefore, this proposal was developed according to the specific needs of expectant mothers, current research on best practices in group counselling and general information available on coping with stress. The group's usefulness is unknown until the proposal can be actualized; modifications to the program will be made based on experience with the group and input from its participants.

Implications for Practice

Reducing prenatal stress has substantial implications for clinical practice. Improving the experience of expectant mothers could ease some of the stressors they experience in transition to motherhood which is already a highly stressful time physically and emotionally. Therefore, creating natural supports for some of the issues they might otherwise seek health care/mental health support for. Decreasing stress during pregnancy

could also help lessen prenatal psychological health problems as they are linked to a continuum of health effects seen in infants and children. Consequently, health problems experienced in childhood are linked to a developmental continuum from childhood into adulthood. Intervention programs targeted specifically towards pregnant women might reduce maternal stress and have protective effects for children.

The proposed program will contain a psychoeducational component that will provide health information to pregnant women. The six-session psychoeducational counselling program will give health care professionals (e.g., counsellors, social workers, mental health workers, obstetricians) the opportunity to refer pregnant women for group counselling in order to deal with stress during pregnancy. Additionally, the group counselling program will allow expectant mothers to connect with other pregnant women experiencing stress. The social context of the group will allow pregnant women to create a personal network to support their experience of becoming mothers.

Implications for Further Research

Psychoeducational groups catered to pregnant women experiencing stress create many implications for further research. An area for further research may include the buffering impact of social support for pregnant women since lower levels of social support exacerbate the effects of stress. According to Koeske & Koeske (1990) “stress produced debilitating effects particularly or exclusively for mothers lacking adequate social support” (p. 448). It would be useful to examine what types of support are beneficial to expectant women.

Additional areas for further research would include studying the effects of prenatal stress on different ethnic groups, women that may come from lower

socioeconomic status and women in strained relationships (Bergman et al., 2007; DiPietro, Hilton, Hawkins, Costigan & Pressman, 2002; Collins et al., 1993; Ruiz & Avant, 2005). These groups are often at risk for chronic stress. Marginalized and economically disadvantaged women are more likely to experience stress in the form of discrimination, isolation, poverty, and harassment (Cormier & Nurius, 2003). “Lower socioeconomic status and poverty create complex confounders of stress” (Ruiz & Avant, 2005, p.348). With respect to ethnic groups, it would be useful to understand the role cultural norms play in one’s ability to access social resources.

Women in strained partner relationships warrant further support and intervention services. Prenatal partner relationship strain made up for 73.5% of the prenatal stress related variance on infant cognitive development in a recent study (Bergman et al., 2007). Similarly Collins et al. (1993) stated that women who were dissatisfied in the support they received from their baby’s father were at greater risk for depressed mood during pregnancy. Examining the specific needs of pregnant women in strained relationships may warrant a psychoeducational support group focused on interventions on women with relational stressors.

Additional research is required make the provision of supplemental services available to expectant mothers whose resources are inadequate in these areas. These findings carry implications for further research as group counselling could benefit the specific needs of these disadvantaged populations.

Summary

Based on the literature and clinical experience there seems to be a great need for a group that focuses on the special needs of expectant women. There are many strengths and limitations of this proposal given that the usefulness of the program will not be understood until the group is actualized. Notwithstanding the limitations of the Happy Moms and Happy Babes Group Program, this project was undertaken with the intention to provide stress related psychoeducation, social support and stress reduction techniques during pregnancy. During the creation of this program, additional implications for further research emerged, and work in these areas needs to be addressed. But as the author of this program, I feel that additional implications offer exciting opportunities for further development. I feel that the areas that need further development may have a profound impact on the health and well being of expectant women and their children.

Since limited research exists to support interventions for prenatal stress, I have created this manual with careful consideration of what is available for reducing stress. There are general stress reduction techniques that have been used in non-pregnant women that have resulted in a buffering effect against stress. These techniques include relaxation training, cognitive behavioural therapy and breathing exercises, and have been presented in the group manual that follows this summary. The manual was also created from my personal experience of pregnancy in the past and again during the development of this program. The most important areas that attributed to a reduction in my stress level throughout my existing and previous pregnancies included connecting with other mothers, validation of my experiences, and psychoeducational information, and

interventions for stress. My experience as a woman, mother, counsellor and academic have shaped this project into one I hope will be useful to other mothers-to-be.

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Appendix A

Assessment of Client Progress- Individual member (Weekly)

0 = Not at all 1 = slightly 2 = Somewhat 3 = Pretty Much 4 = Very Much

NOTE: Please complete at the end of the session (5 minutes) and give assessment to one of the leaders.

As a result of tonight's group,

1) I Realized something new about myself	1	2	3	4
2) I am more aware of my feelings	1	2	3	4
3) I feel my counsellor understands me	1	2	3	4
4) I feel supported in the group	1	2	3	4
5) I feel comfortable in the group	1	2	3	4
6) I feel closer to my counsellor	1	2	3	4
7) I feel closer to my group members	1	2	3	4
8) I can explore personal feelings	1	2	3	4
9) I can express previously inhibited feelings	1	2	3	4
10) I am hopeful	1	2	3	4
11) I accept myself	1	2	3	4

Adapted from the Group Counseling Helpful Impacts Scale in Kivlighan, D. M., Multon, K. D., & Brossart, D. F. (1996). Helpful impacts in group counseling: Development of a multidimensional rating system. *Journal of Counseling Psychology, 43*, 347-355.

Appendix B

Assessment of client progress

0 = Not at all 1 = slightly 2 = Somewhat 3 = Pretty Much 4 = Very Much
As a result of the group,

1) I can discuss my feelings and thoughts	1	2	3	4
2) I can discuss my relationship to others	1	2	3	4
3) I can request feedback from others	1	2	3	4
4) I can express positive feelings	1	2	3	4
5) I accept myself	1	2	3	4
6) I communicate directly with others	1	2	3	4
7) I communicate effectively with others	1	2	3	4
8) I can take a risk of revealing my feelings	1	2	3	4
9) I can express change of attitude	1	2	3	4
10) I can express a closeness to others	1	2	3	4
11) I can express negative feelings	1	2	3	4
12) I can discuss others' feelings	1	2	3	4
13) I can understand what happens between others	1	2	3	4

Adapted from the Interpersonal Relations Scale Checklist in Kivlighan, D. M., Jauquet, C. A., Hardie, A. W., Francis, A., & Hershberger, B. (1993). Training group members to set session agendas: Effects on in-session behavior and member outcome. *Journal of Counseling Psychology, 40*, 182-187.

Appendix C

Group Therapy Progress Notes

Client name: _____ Date: _____

Session start: _____ Group: Pregnancy and Stress

Session end: _____ Current GAF: _____

Group topics discussed:

Observational Ratings:

Low	Medium	High
-----	--------	------

Participated in the group

Motivation

Shared emotions

Disclosed information about self

Participated in positive interactions

Listened to others

Supported others

Progressing towards identified goals

Individual Contributions to this group session:

Counsellor Signature _____

Adapted from Wiger, D. E. (1999). *The clinical documentation sourcebook*. New York:

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Appendix D

Informed Consent Form

Informed Consent Form***Happy Moms and Happy Babes Group Program***

INFORMED CONSENT STATEMENT

I, _____, have met with the group leader and am aware of the purpose of the group. The group will focus on managing stress and setting positive life goals. The topics discussed will include: the nature of stress, mind and soul, coping strategies, social support, and relaxation techniques. These skills are helpful for those experiencing stress during pregnancy. The group will run for six weeks and two Group therapists will lead the group. I have learned about the strategies and techniques that will be part of this group experience. The leader has indicated limitations in her/his practice as well as the areas of expertise. I understand that the group leaders are receiving on-going supervision of their professional work.

As a group member I have rights and benefits as well as duties. I understand the importance of confidentiality and the caveats to confidentiality. If I breach confidentiality I will be asked to leave the group. I also understand that the group leader cannot promise confidentiality from other group members and any information I share with the group leader may be shared with the group.

I agree to work in the group and I will actively participate with the group leader and I am willing to participate with other group members to help reach personal and group goals. The purpose of this group is to provide me with the opportunity to work on the following goals:

- 1)
- 2)
- 3)

I am entering this group voluntarily and I understand that at anytime I can withdraw from the group if I feel it is not meeting my needs. If I decide to leave the group, I will discuss my reasons for leaving. I will make the effort to inform the group with at least 2 weeks' notice to allow for proper closure.

Please sign below to indicate your willing consent to participate in this group.

Group Member Signature

Group Leader Signature

Date: _____

Appendix E
DASS 21

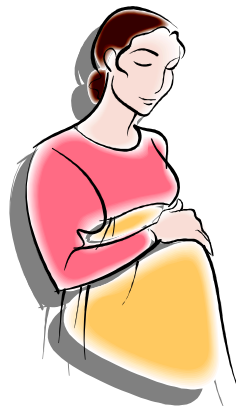
DASS21		<i>Name:</i>		<i>Date:</i>	
<p>Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you <i>over the past week</i>. There are no right or wrong answers. Do not spend too much time on any statement.</p> <p><i>The rating scale is as follows:</i></p> <p>0 Did not apply to me at all 1 Applied to me to some degree, or some of the time 2 Applied to me to a considerable degree, or a good part of time 3 Applied to me very much, or most of the time</p>					
1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (e.g., in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3
<p>Antony, M.M., Bieling, P.J., Cox, B.J., Enns, M.W. & Swinson, R.P. (1998). Psychometric properties of the 42-item and 21-item versions of the Depression Anxiety Stress Scales (DASS) in clinical groups and a community sample. <i>Psychological Assessment</i>, 10, 176-181.</p>					

Appendix F

Happy Moms and Happy Babes Group Leader's Manual

Happy Moms and Happy Babes Psychoeducational Group Program

**Happy Moms and Happy Babes:
A Group Program for Expectant
Moms**



Orientation Handouts

Handout Number 1, Orientation: Member Expectations
Chen, M., & Rybak, C. (2004). *Group leadership skills: Interpersonal process in group counseling and therapy*. Toronto, Ont: Thomson Nelson. Appendix B (pp. 386-393):
Orientation handouts

Member Rights:

- Right to be treated with respect by the leader and other members
- Right to be free from coercion from group leaders and members
- Right to leave the group if the group is not meeting their needs
- Right to know how the leader will conduct the group
- Right to decide what to share (personal subjects)
- Right to physical and emotional welfare
- Right to know the purpose of the group
- Right to voluntary participation
- Right to follow-up services
- Right to confidentiality

Member Responsibilities:

- Contact group leaders upon deciding to leave the group
- Attend group meetings
- Cooperate in evaluating services
- Respect confidentiality
- Actively participate



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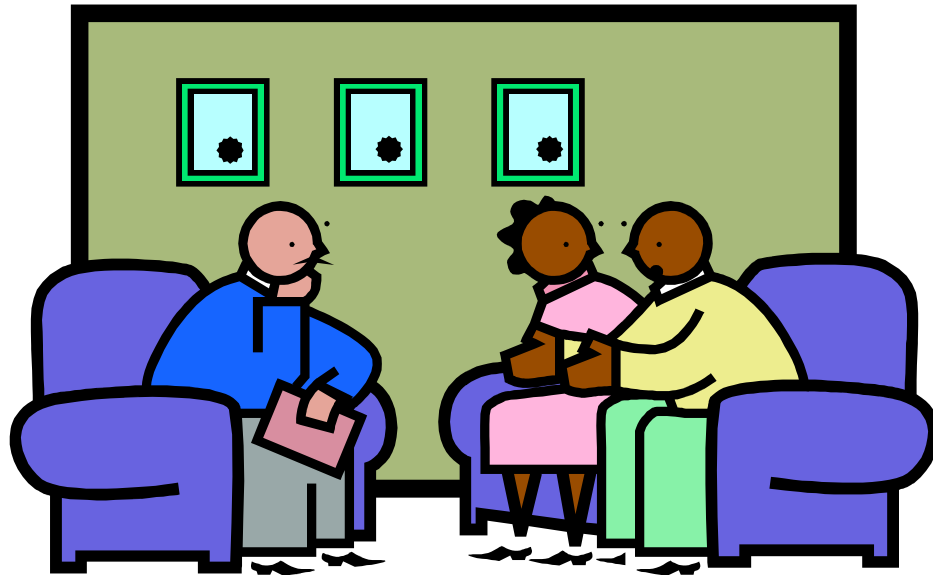
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Handout Number 2, Orientation: Group Leader Expectations
Chen, M., & Rybak, C. (2004). *Group leadership skills: Interpersonal process in group counseling and therapy*. Toronto, Ont: Thomson Nelson. Appendix B (pp. 386-393):
Orientation handouts

Group Leader Expectations:

- I. The group leaders will use their knowledge and experience to facilitate the group
- II. The leaders will focus on creating an atmosphere of support and trust so that members will feel safety and a willingness to self disclose
- III. They will assist all members to participate
- IV. Leaders will support members in identifying interpersonal strengths and barriers
- V. Leaders will be less active when group members are actively engaged with each other
- VI. Leaders will encourage members to ask for assistance
- VII. Leaders will encourage members to approach the leaders regarding any issues with the leaders' roles and activities



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[ca/clipart/results.aspx?qu=therapy&sc=20&DownloadAssetId=MCj03980970000&DownloadExtension=wmf&AxInstalled=1&c=0](http://office.microsoft.com/en-ca/clipart/results.aspx?qu=therapy&sc=20&DownloadAssetId=MCj03980970000&DownloadExtension=wmf&AxInstalled=1&c=0)

Handout Number 3, Orientation: What to expect
Chen, M., & Rybak, C. (2004). *Group leadership skills: Interpersonal process in group counseling and therapy*. Toronto, Ont: Thomson Nelson. Appendix B (pp. 386-393):
Orientation handouts

What to expect from Happy Moms and Happy Babes Group:

- I. The chance to engage in reciprocal and supportive relationships with other group members
- II. The chance to relate to others who may be facing the same concerns as you
- III. To increase self awareness through identification of life themes that are interfering with your growth
- IV. To become more sensitive to others and to respect the individuality of others
- V. The opportunity to gain immediate feedback
- VI. The opportunity to try new ways of thinking and behaving and also to express feelings

The more you invest the more you benefit!!!!!!



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Retrieved July 23, 2009, from

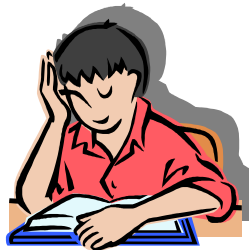
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Handout Number 4, Orientation: What to expect

Adapted from Chen, M., & Rybak, C. (2004). *Group leadership skills: Interpersonal process in group counseling and therapy*. Toronto, Ont: Thomson Nelson. Appendix B (pp. 386-393): Orientation handouts

How to get the most out of the group:

- I. Be yourself
- II. Define goals
- III. Recognize and respect your pace for getting involved and sharing in the group
- IV. Take time for yourself and talks about yourself
- V. Focus on your needs and what is important to you
- VI. Recognize and express feelings and thoughts
- VII. Be open to receiving and processing feedback from the group
- VIII. Be an active member
- IX. Take risks
- X. Be prepared for role plays and link your role to your family of origin
- XI. Be aware of distancing behaviours
- XII. Respond to others
- XIII. Be patient with yourself and give the group time to develop
- XIV. Work outside the group- apply your learning
- XV. Decide on how much you want to disclose
- XVI. Keep a journal of your learning in the group

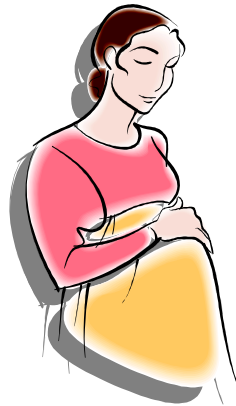


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**Happy Moms and Happy Babes:
A Group Program for Expectant
Moms**



**Session 1 Plan:
Introductions and Support**

Session #1: Introductions and Support

Objectives:

- 1-Group members to begin developing relationships by sharing personal information and relating to others and their experiences (Corey & Corey, 2006).
- 2-Explore expectations and goals of group members (Corey & Corey, 2006)

Preparation:

- Co-facilitator meeting to review information and roles
- Prepare handouts and flipchart information
- Prepare group space and refreshments/snacks

Materials:

- Flipchart stand and paper
- Nametags
- Diaper
- Markers, pens and paper
- Handouts #1- 4 for Session #1

Topic & Time	Activity	Notes & Supplies
Introductions 10 min.	<ul style="list-style-type: none"> - Welcome members, discuss agenda for first meeting - Allow round-table introductions for members, i.e. name, stage of pregnancy, something they hope to gain from participating in the group 	<ul style="list-style-type: none"> - Create atmosphere of connection to each member
Group expectations 15 min.	<ul style="list-style-type: none"> - Discuss purpose of group, expectations for discussion/participation - Review guidelines, i.e. confidentiality - Facilitate discussion of group safety 	<ul style="list-style-type: none"> - May need to define safety, help members understand when they are triggered and what their options are for managing this - Respond to questions
Dyad interactions 10 min.	<ul style="list-style-type: none"> -pair up and discuss what fears/challenges they are experiencing attending the group 	<ul style="list-style-type: none"> Support connection between members as they participate in dyads
Icebreaker activity 20 min.	<ul style="list-style-type: none"> - Facilitate “fear in a hat” activity 	<ul style="list-style-type: none"> - Leader copy of fear in a hat guidelines - Paper bag (or hat)
BREAK 15 min.		<ul style="list-style-type: none"> NEED: Snack
Social support: Building healthy relationships 20 min.	<ul style="list-style-type: none"> - Leader provides instruction and distributes handout - Groups discussion of what 	<ul style="list-style-type: none"> - Support discussion and connections between members NEED: 1 copy of handout #1

	builds healthy relationships	for each member
Social support: opening ourselves to others 20 min.	<ul style="list-style-type: none"> - Leader guide discussion as per the group's needs regarding building supportive relationships - Dyad discussions (different pairs than before) of how we open ourselves to support, connection 	<ul style="list-style-type: none"> - Move among dyads and support experience of connecting, opening to each other - NEED: 1 copy of Leader Handout #1
Check-out and evaluation 10 min.	<ul style="list-style-type: none"> - Round-table check-out, one sentence on your feelings as the first group ends - Distribute evaluation for members to complete before leaving 	<ul style="list-style-type: none"> - Facilitators support active listening and no cross-talk rules as necessary NEED: 1 copy of weekly "client satisfaction" evaluation for each member

Leader Handout Number 1, Session 1: "Fear in a Diaper"
<http://wilderdom.com/games/descriptions/FearInAHat.html>
James Neill

Fear in a Diaper

Group Interpersonal Understanding Exercise

Brief description:

People write personal fears anonymously on pieces of paper which are collected. Then each person reads someone else's fear to group and explains how the person might feel.

Fear in a Diaper

- The group leader needs to set an appropriate tone, e.g., settled, attentive, caring and serious.
- The group leader states that the topic is the fears and anxieties of pregnancy. Fears, worries and anxiety are normal and a natural experience of pregnancy. To deal with these fears is to put them out in the open and acknowledge them without being subject to ridicule. Group leader states the following- "Having your fears heard can help one feel relieved and can cut your fears in half."
- **NOTE: Leader-** The purpose of this group activity it can help to foster group support
- Ask everyone, to complete this sentence on a piece of paper (anonymously): "At this moment I stress about in pregnancy"
- Collect the pieces of paper, mix them around, then invite each person to a piece of paper and read about someone's stress.
- One by one, each group member reads out the fear of another group member and elaborates and what he/she feels that person is most stressed about in pregnancy. No one is to comment on what the person says, just listen and move on to the next person.
- When all the fears have been read out and elaborated on, then discuss what each group member felt and experienced.

Time:

~5 minutes + 1-2 minutes per participant (20 minutes for a group of 8).

Equipment: Paper and pen/pencil per participant; diaper.

Handout Number 1, Session 1: Open up to others

Building Supportive Relationships

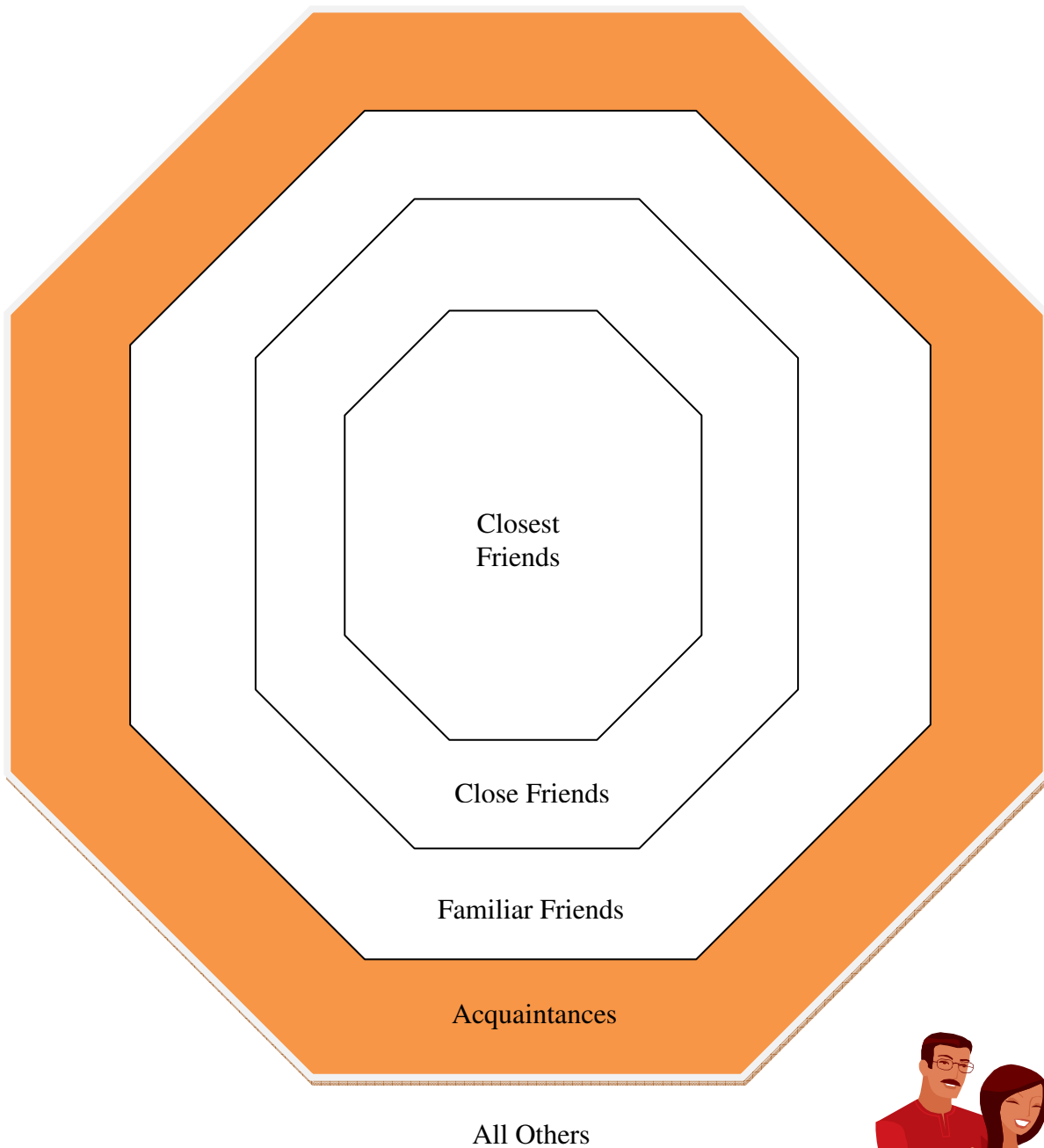
On the following page, write down the initials of your closest friend and/or family members in the smallest octagon. This would include all those individuals that you are comfortable with talking about your most personal issues. In the next octagon write the initials of those individuals who are very close to you such as your close friends. The next octagon would be friends that you are familiar with. Next larger octagon would be your acquaintances. Next, people you see often but you may not know their names. You could use a symbol to represent them. For example, the person you sometimes see at the grocery store would be a bag with grocery written on it.

STEP 1: Assess which individuals create healthy relationship dynamics and which relationships don't.

STEP 2: Assess boundaries in each relationship that you have identified and determine what needs to change in these relationship. As you reflect on these relationships, consider who you would like to move closer to the centre of your circle and who you might like to move further from the centre. Reflect on how these relationships are supporting you or detracting from you being the person you most want to be.

STEP 3: circle the people you want to have a closer relationship with and make a plan for how you will act towards that in the coming week. That may mean a lunch date or a coffee date. Use these people in the diagram as your social network in times of stress to express your thoughts and feelings.

Build Supportive Relationships



Leader Handout Number 2, Session 1: Open Up to Others

Open your life to others

Social support is one of the most effective means of managing stress and that includes talking to friends and family. Managing stress is best done when you can share your feelings with others. The best stress managers have a circle of supportive relationships.

Supportive relationships are ones that two people feel mutually comfortable sharing thoughts and feelings with another. Building supportive relationships means spending time with friends and family that you wish to know better.

Exercise:

Determine who is a good support for you in stressful times. What do they do or not do that makes them a good source of support. What qualities make them a good source of support? Share with others in the group.



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Handout Number 2, Session 1: Assessment of client progress

Assessment of Client Progress- Individual member (Weekly)

0 = Not at all **1** = Slightly **2** = Somewhat **3** = Pretty Much **4** = Very Much

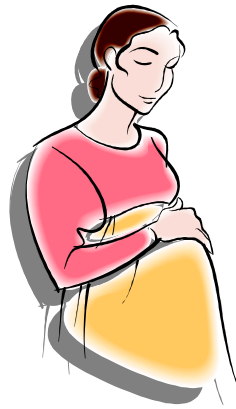
NOTE: Please complete at the end of the session (5 minutes) and give assessment to one of the leaders.

As a result of tonight's group,

1) I Realized something new about myself	1	2	3	4
2) I am more aware of my feelings	1	2	3	4
3) I Felt my counsellor understands me	1	2	3	4
4) I Feel supported in the group	1	2	3	4
5) I feel comfortable in the group	1	2	3	4
6) I feel closer to my counsellor	1	2	3	4
7) I feel closer to my group members	1	2	3	4
8) I can explore personal feelings	1	2	3	4
9) I can express previously inhibited feelings	1	2	3	4
10) I feel hopeful	1	2	3	4
11) I accept myself	1	2	3	4

Adapted from the Group Counseling Helpful Impacts Scale in Kivlighan, D. M., Multon, K. D., & Brossart, D. F. (1996). Helpful impacts in group counseling: Development of a multidimensional rating system. *Journal of Counseling Psychology, 43*, 347-355.

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Session 2 Plan: The Nature of Stress

Session #2: The Nature of Stress

Objectives:

- 1-Continue to build social support network among group members through sharing and relating to others in the group (mutual empathy and self empathy)
- 2-Examine the concept of stress
- 2-Identify each participants personal definition of stress (link differences and similarities in the experience of stress)
- 3- Assess each members level of stress (pregnancy and non-pregnancy related) and how it effects us physically, emotionally, behaviourally and mentally

Preparation:

- Co-facilitator meeting to review information and roles
- Prepare handouts and flipchart information
- Prepare group space and refreshments/snacks

Materials:

- Flipchart notes and DVD player with movie clip
- Name tags, markers, pens and paper
- Handouts #1-5 for Session #2

Topic & Time	Activity	Notes & Supplies
Check-In 10 min.	<ul style="list-style-type: none"> - Check in with each participant -Provide each participant the opportunity to see how they are feeling -Explore any questions or concerns that the group members may have from session 1 	<ul style="list-style-type: none"> -Open discussion to the group -Leader to respond to questions -Create atmosphere of connection to each member
Culture and motherhood 15 min.	<ul style="list-style-type: none"> -Group leaders to read questions to group members (Leader handout #1 Session 2: Exploring culture and the meaning of stress) 	<ul style="list-style-type: none"> Open discussion to the group -May need to help members understand that stress can be experienced differently in some cultures - Build trust with sharing of experience NEED: 1 Copy of Leader handout #1 Session 2
Movie clip-“Moms around the world: Earth’s mothers”- Oprah Winfrey 5 min.	<ul style="list-style-type: none"> - Debrief movie clip in larger group. Identify key themes in video clip 	<ul style="list-style-type: none"> Opportunity for each member to share her experience of becoming a mother and identification with others in the group NEED: DVD player and video

		clip
Break 15 min.	- Members to have a break and snack	Snack
Stress Test Freudenberger & Richelson) 10 min.	-Complete self assessment individually	Provide handout #1 Session 2: Stress Test NEED: 1 copy of handout #1 for each member
Personal definition of stress 10 min.	- Group leaders to facilitate discussion around different meanings of stress (culture) flip-chart discussion	- Facilitate discussion with larger group NEED: Flip chart and felt
What is stress? (Posen, 2003, p. 193) 10 min.	- Group leaders to facilitate open discussion about “good and bad stress”	- Provide handout #2, Session 2: What is stress? -NOTE: provide handout after topic opened up to group NEED: 1 copy of handout for each member NEED: flip chart and felt
Symptoms of stress (Posen, 2003, p. 194-195) 10 min.	- Group leaders to facilitate open discussion about the symptoms of stress and have group members identify some of the symptoms they have been experiencing	- Provide handout #3, Session 2: What are the symptoms of stress? -NOTE: provide handout after topic opened up to the group NEED: 1 copy of handout for each member - Encourage questions and comments from participants
External and internal sources of stress/pregnancy related stress (Wright, 1997, p. 13) (Posen, 2003, p. 196-198) 10 min.	-Round table discussion identifying group themes (common stressors -pregnancy specific and non pregnancy specific	-Provide handout #4, Session 2: pages 1-3: Sources of stress -Encourage questions and comments from participants -NOTE: provide handout after topic opened up to group - Create atmosphere of connection to each member and the experience of being women with a shared experiences - Encourage questions and comments from participants
Check-out and evaluation 5min.	- Round table check-out, one word that describes your feelings as the session ends -Each member needs to complete session evaluation	- Facilitators support active listening NEED: 1 copy of handout #5, Session 2: Assessment of client satisfaction (Weekly)

Leader Handout Number 1, Session 2: Exploring Culture

Culture and what it means to us individually

Every individual develops a particular worldview on life based on their ethnic identity, cultural background, and socioeconomic status. The concept of motherhood is linked to our experiences from childhood and our unique culture and heritage.

- Can you share something with the group that is unique about yourself?
- How do you identify your race or ethnicity? (Corey & Corey, 2006)
- What does the word family mean to you?
- What family/parenting values are most important to you?
- Where did you learn these values?
- What does the word mother mean to you and how is that linked to your culture/ethnicity?

Movie clip-“Moms around the world: Earth’s mothers”- Oprah Winfrey

Show members short video clip of mothers around the world (e.g. “Moms around the world: Earth’s mothers”- Oprah Winfrey).

<http://boutique.oprah.com/product/show/5911>

Group leaders to debrief movie clip in larger group. Identify key themes in video clip

Handout Number 1, Session 2: Stress Test.

Adapted from Herbert J. Freudenberger and Geraldine Richelson, *Burnout: How to Beat the High cost of High Achievement*. New York: Doubleday.

Stress Test

Rating Scale: 1- no change, 2= little change, 3= moderate change, 4= considerable change, 5= great deal of change

1. Do you tire more easily? Feel fatigued rather than energetic? _____
2. Are people annoying you by telling you, "You don't look so good lately?" _____
3. Are you working harder and harder and accomplishing less and less _____
4. Are you increasingly cynical and disenchanted? _____
5. Are you often invaded by a sadness you cannot explain? _____
6. Are you forgetting appointments and personal possessions? _____
7. Are you increasingly irritable? More short-tempered? _____
8. Are you seeing close friends and family members less frequently? _____
9. Are you too busy to do even routine things such as making phone calls? _____
10. Are you suffering from physical complaints (headaches, aches) _____
11. Do you feel disoriented when the activity of the day comes to a halt? _____
12. Is joy elusive _____
13. Are you unable to laugh at a joke about yourself? _____
14. Do you have very little to say to people? _____

Total _____

Scoring:

0-25: You are doing fine

26-35: There are a few things you should watch

36-50: You are a candidate for cumulative stress

51-65: You are well into cumulative stress

Over 65: You are stressed. Your physical and mental health are threatened



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Handout Number 2, Session 2: What is Stress?

Posen, D. (2003). The little book of stress relief. Toronto. Key Porter Books Limited.

What is stress?

Stress is the body's response to people, places or events. It is an internal reaction.

Distress: is bad stress. It is unpleasant and damaging physical response to stress. When managed poorly or allowed to get out of control it becomes negative.

Eustress: is good stress. It causes motivating influences.

Stress is necessary to life and survival. It can be positive and beneficial (eustress) or it can be negative and detrimental (distress)

What happens during a stress reaction?

There is an increase in

- heart rate
- blood pressure
- breathing rate muscle tension
- perspiration
- mental alertness and senses are heightened
- blood flow to the heart, brain and muscles
- blood sugar, cholesterol, platelets, and clotting factors

There is a decrease in

- blood flow to the skin
- blood flow to the digestive tract
- blood flow to the kidneys
-



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Handout Number 3, Session 2: What are the symptoms of stress?
Posen, D. (2003). *The little book of stress relief*. Toronto, Key Porter Books Limited.

Recognition, Detection and Awareness- Symptoms may include any combination of the following:

Physical Symptoms

- Headache
- Dizziness
- Clenching jaw, grinding teeth
- Chest pain or tightness
- Nausea, vomiting, heartburn, indigestion, cramps
- Shaking trembling,
- Agitation, feeling hyper
- Sleep disturbance
- Frequent colds

Mental Symptoms

- Decrease in concentration and increased forgetfulness
- Loss of decisiveness
- Decrease in humor
- Mind racing, drawing blanks or confusion

Emotional Symptoms

- Anxiety, tension or nervousness
- Depression, sadness
- Fear, worry, pessimism
- Loss of motivation
- Impatience

Behavioural Symptoms

- Fidgeting, pacing restlessness
- Compulsive smoking, drinking, overeating
- Nail biting
- Blaming, yelling, swearing
- Crying, weeping, feeling on the verge of tears



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Handout Number 4, Session 2: What are the sources of stress?
Posen, D. (2003). The little book of stress relief. Toronto. Key Porter Books Limited.

External and Internal Sources of Stress

External Sources (Stressors)

1. Physical

- noise, heat, clutter, confined spaces, lack of windows, humidity

2. Social

- relationship problems, work relationships, crowds, parties, strangers, rude aggressive or competitive people,
- unreliable, moody, indecisive people

3. Major Life Events

- Having a child, getting married, moving to a new house, illness
- Changes in life circumstances may be negative or positive



4. Daily Hassles

- Rush hour traffic, fear of crime, misplacing things, rising prices

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Handout Number 4-page 2, Session 2: What are the sources of stress?
Posen, D. (2003). The little book of stress relief. Toronto. Key Porter Books Limited.

Internal Stressors

1. Lifestyle choices

- health habits including caffeine intake, insufficient sleep, poor nutrition, tobacco, drugs
- social isolation
- financial overextension



2. Negative self-talk

- critical, judgemental, insulting or blaming thoughts
- bossiness
- destructive emotions: guilt, worry, regret, resentment, jealousy
- pessimism, cynicism, suspicion
- undermining or self defeating comparisons
- ruminating, wallowing, overanalyzing, and second guessing

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Handout Number 4-page 3, Session 2: What are the sources of stress?
Posen, D. (2003). The little book of stress relief. Toronto. Key Porter Books Limited.

3. Interpretation of events

- perceiving something as a danger or threat
- feeling a lack of control
- jumping to conclusions about other people's motives
- feeling not "good" about yourself

4. Mind traps

- unrealistic expectations
- over identifying with roles, possessions
- taking things personally
- taking on other people's problems as if they are your own
- exaggerating or generalizing

5. Belief Systems

- outdated beliefs
- inaccurate beliefs
- negative beliefs

6. Stress Prone Personality Types

- overachievers
- Type A personalities
- perfectionism
- pleasers
- caretakers
- victims



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Handout Number 5, Session 2: Assessment of client progress

Assessment of Client Progress- Individual member (Weekly)

0 = Not at all **1** = Slightly **2** = Somewhat **3** = Pretty Much **4** = Very Much

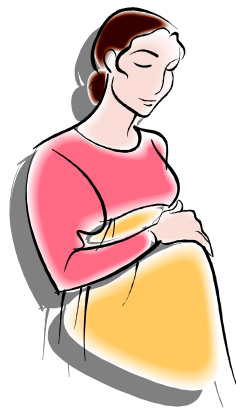
NOTE: Please complete at the end of the session (5 minutes) and give assessment to one of the leaders.

As a result of tonight's group,

1) I Realized something new about myself	1	2	3	4
2) I am more aware of my feelings	1	2	3	4
3) I Felt my counsellor understands me	1	2	3	4
4) I Feel supported in the group	1	2	3	4
5) I feel comfortable in the group	1	2	3	4
6) I feel closer to my counsellor	1	2	3	4
7) I feel closer to my group members	1	2	3	4
8) I can explore personal feelings	1	2	3	4
9) I can express previously inhibited feelings	1	2	3	4
10) I feel hopeful	1	2	3	4
11) I accept myself	1	2	3	4

Adapted from the Group Counseling Helpful Impacts Scale in Kivlighan, D. M., Multon, K. D., & Brossart, D. F. (1996). Helpful impacts in group counseling: Development of a multidimensional rating system. *Journal of Counseling Psychology, 43*, 347-355.

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**Session 3 Plan:
Cognitive Reframing**

Session #3: Cognitive Reframing

Objectives:

- 1- Continue to build social support network among group members through sharing and relating to others in the group (mutual empathy and self empathy)
- 2- Have members understand the relationship between anxiety provoking self talk/ personal belief systems and how this affects one's experience of stress. Help members understand that feelings are influenced by our thoughts and perceptions.
- 3- Learn to counter negative self talk with more supportive, realistic, constructive and calming statements

Preparation:

- Co-facilitator meeting to review information and roles
- Prepare handouts and flipchart information
- Prepare group space and refreshments/snacks

Materials:

- Flipchart stand and paper
- Nametags
- Markers, pens and paper
- Handouts #1-3 for Session #3

Topic & Time	Activity	Notes & Supplies
Check-In 15 min.	- Check-in to help members reconnect -Check-in with each member by having them identify an animal that describes how they are feeling in the here and now -Process last week and explore any questions or concerns that the group members may have from session 2	- Provide each member the opportunity to see how they are feeling - Open up discussion to group -Create atmosphere of connection to each member
Stinkin' Thinkin' (objective #1) (Burns, 1989, p.8-9) 30 min.	- Flip-chart discussion -Group leaders facilitate -10 forms of twisted thinking	Have group members identify forms of twisted thinking. If needed, have the group work in pairs and then facilitate a larger discussion afterwards -NEED: Handout #1, Session 3: Ten forms of twisted thinking NEED: Flipchart and felt
Break 15 min.	- Members to have a break and snack	Snack
Changing your thinking (Cormier & Nurius, 2003) 15 min.	- Leaders facilitate discussion	

<p>Daily mood log (Objective #2) (Burns, 1989, p. 75-77) 10 min.</p>	<ul style="list-style-type: none"> - Leaders to facilitate discussion -members participate in understanding how to self monitor thoughts emotions and behaviours 	<p>NEED: Daily mood log Handout #2, Session 3 for each member NOTE: Facilitator Handout Number 1, Session 3: The Daily Mood Log NEED: Flip chart and felt</p>
<p>Daily mood log 10 min.</p>	<ul style="list-style-type: none"> - Individually complete daily mood log 	
<p>Daily mood log Cont'd 15 min.</p>	<ul style="list-style-type: none"> -In small groups have each member discuss their example from their mood log 	<p>Remind group of rules for discussion (being open and supportive of others) -Create atmosphere of connection to each member and the experience of being women with a shared experiences - Encourage questions and comments from participants</p>
<p>External and internal sources of stress/pregnancy related stress (Wright, 1997, p. 13) (Posen, 2003, p. 196-198) 10 min.</p>	<ul style="list-style-type: none"> -Round table discussion identifying group themes (common stressors -pregnancy specific and non pregnancy specific 	<ul style="list-style-type: none"> -Provide handout #4, Session 2: pages 1-3: Sources of stress -Encourage questions and comments from participants -NOTE: provide handout after topic opened up to group - Create atmosphere of connection to each member and the experience of being women with a shared experiences - Encourage questions and comments from participants
<p>Check-out and evaluation 10 min.</p>	<ul style="list-style-type: none"> - - Round table check-out, one word that describes your feelings as the session ends -Distribute evaluation for members to complete before leaving 	<ul style="list-style-type: none"> - Facilitators support active listening <p>NEED: 1 copy of handout #5, Session 3: Assessment of client satisfaction (Weekly)</p>

Handout Number 1, Session 3: 10 Forms of Twisted Thinking
Burns, D. (1989). *The feeling good handbook*. New York, NY: Penguin Group

Ten Forms of Twisted Thinking

- 1. All or nothing thinking-** You see situations in black or white categories. If a situation falls short of perfect, you see it as a total failure
- 2. Overgeneralization-** You see a single negative event as a never ending pattern of defeat, by using the words “always” or “never” when you think about it.
- 3. Mental Filter-** You pick out a single negative detail and dwell on it exclusively so that your vision of all reality becomes darkened.
- 4. Discounting the positive-** You reject positive experiences by insisting they don't count
- 5. Jumping to conclusions-** You interpret things negatively when there are no facts to support your conclusion.
 - **Mind Reading-** Without checking it out , you arbitrarily conclude that someone is reacting negatively towards you
 - **Fortune Telling-** You predict that things will turn out negatively
- 6. Magnification-** You exaggerate the importance of your problems and shortcomings, or you minimize the importance of your desirable qualities
- 7. Emotional Reasoning-** You assume that your negative emotions necessarily reflect the way things really are.

Handout Number 1-page 2, Session 3: 10 Forms of Twisted Thinking
Burns, D. (1989). *The feeling good handbook*. New York, NY: Penguin

8. “Should” statements- You tell yourself that things “should” be the way you hoped or expected them to be. “Should” statements that are directed towards yourself lead to guilt and frustration.

9. Labelling- Is an extreme form of all or nothing thinking. Instead of saying “I made a mistake” you attach a negative label to yourself.

10. Personalization and Blame- Occurs when you hold yourself personally responsible for an event that isn’t entirely under your control.



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Handout Number 2, Session 3: The Daily Mood Log
 Burns, D. (1989). *The feeling good handbook*. New York, NY: Penguin Group.

THE DAILY MOOD LOG*					
STEP ONE: DESCRIBE THE UPSETTING EVENT _____					

STEP TWO: RECORD YOUR NEGATIVE FEELINGS —and rate each one from 0 (the least) to 100 (the most). Use words like sad, anxious, angry, guilty, lonely, hopeless, frustrated, etc.					
Emotion	Rating	Emotion	Rating	Emotion	Rating
1.		3.		5.	
2.		4.		6.	
STEP THREE: THE TRIPLE-COLUMN TECHNIQUE—					
Automatic Thoughts Write your negative thoughts and estimate your belief in each one (0–100).	Distortions Identify the distortions in each Automatic Thought.	Rational Responses Substitute more realistic thoughts and estimate your belief in each one (0 and 100).			
(Continue on next page)					

Handout Number 2-page 2, Session 3: The Daily Mood Log
 Burns, D. (1989). *The feeling good handbook*. New York, NY: Penguin Group.

THE DAILY MOOD LOG (continued)		
Automatic Thoughts	Distortions	Rational Responses

STEP FOUR: OUTCOME—Re-rate your belief in each Automatic Thought from 0 to 100 and put a check in the box that describes how you now feel:

not at all better;
 somewhat better;
 quite a bit better;
 a lot better.

CHECKLIST OF COGNITIVE DISTORTIONS*

1. All-or-nothing thinking: You look at things in absolute, black-and-white categories.
2. Overgeneralization: You view a negative event as a never-ending pattern of defeat.
3. Mental filter: You dwell on the negatives and ignore the positives.
4. Discounting the positives: You insist that your accomplishments or positive qualities "don't count."
5. Jumping to conclusions: (A) Mind reading—you assume that people are reacting negatively to you when there's no definite evidence for this; (B) Fortune-telling—you arbitrarily predict that things will turn out badly.
6. Magnification or minimization: You blow things way up out of proportion or you shrink their importance inappropriately.
7. Emotional reasoning: You reason from how you feel: "I feel like an idiot, so I really must be one." Or "I don't feel like doing this, so I'll put it off."
8. "Should statements": You criticize yourself or other people with "shoulds" or "shouldn'ts." "Musts," "oughts," and "have tos" are similar offenders.
9. Labeling: You identify with your shortcomings. Instead of saying "I made a mistake," you tell yourself, "I'm a jerk," or "a fool," or "a loser."
10. Personalization and blame: You blame yourself for something you weren't entirely responsible for, or you blame other people and overlook ways that your own attitudes and behavior might contribute to a problem.

Facilitator Handout Number 1, Session 3: The Daily Mood Log
 Burns, D. (1989). *The feeling good handbook*. New York, NY: Penguin Group

Notes for facilitators for the DAILY MOOD LOG:

In the daily mood log intervention the member is required to record her automatic thoughts on a daily mood log (Burns, 1989). According to Burns, automatic thoughts are the fleeting thoughts that reflect an appraisal of a situation and disregard the actual objective situation.

Step 1 on the log requires the member to write a brief description of a specific problem that's bothering her each day. It is important to explain the significance of being specific.

Step 2 requires her to record her negative feelings and rate them from 0 (the least) to 100 (the most). The leader should ask her to use words like sad, anxious, angry, guilty, lonely, hopeless etc. According to Burns (1989), rating the negative feelings may appear artificial but is an effective task. For example a client may feel guilt and rates the guilt at 100. When the guilt decreases from 100 to 50 they might still feel uneasy but they are feeling better. This process gives the group member the opportunity to give themselves credit and also helps with increasing confidence.

Step 3 requires the member to use the triple column technique (Burns, 1989).

-Column 1 requires her to identify the automatic thoughts that are associated with the upsetting event. She also needs to estimate her belief in each automatic thought from 0 to 100. According to Burns the act of identifying automatic thoughts, offers clients some reprieve because they are structuring the problem, and gaining distance from their thoughts.

-Column 2 requires her to identify distortions in each automatic thought. The member has already been provided a checklist of cognitive distortions that she could refer to when she is working through her mood log.

-Column 3 requires her to substitute more realistic thoughts and an estimate of her belief in each one of them. After the automatic thoughts are identified and answered the member crosses out the original percentage and rates each one with a new estimate of how much they believe in light of the rational response (Burns).

Step 4 requires the member to check a box that describes how she feels and the four statements include: a) not at all better; b) somewhat better; c) quite a bit better; and d) alot better. The leader can provide the member with an example of a completed thought log for reference (Burns).



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Handout Number 3, Session 3: Assessment of client progress

Assessment of Client Progress- Individual member (Weekly)

0 = Not at all **1** = Slightly **2** = Somewhat **3** = Pretty Much **4** = Very Much

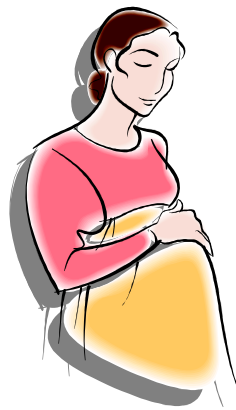
NOTE: Please complete at the end of the session (5 minutes) and give assessment to one of the leaders.

As a result of tonight's group,

1) I Realized something new about myself	1	2	3	4
2) I am more aware of my feelings	1	2	3	4
3) I Felt my counsellor understands me	1	2	3	4
4) I Feel supported in the group	1	2	3	4
5) I feel comfortable in the group	1	2	3	4
6) I feel closer to my counsellor	1	2	3	4
7) I feel closer to my group members	1	2	3	4
8) I can explore personal feelings	1	2	3	4
9) I can express previously inhibited feelings	1	2	3	4
10) I feel hopeful	1	2	3	4
11) I accept myself	1	2	3	4

Adapted from the Group Counseling Helpful Impacts Scale in Kivlighan, D. M., Multon, K. D., & Brossart, D. F. (1996). Helpful impacts in group counseling: Development of a multidimensional rating system. *Journal of Counseling Psychology, 43*, 347-355.

**Happy Moms and Happy Babes:
A Group Program for Expectant
Moms**



Session 4 Plan:

Assertiveness

Session #4: Assertiveness

Objectives:

- 1- Continue to build social support network among group members through sharing and relating to others in the group (mutual empathy and self empathy)
- 2-Examine the concept of assertiveness and how it relates to expression of feelings and self awareness
- 3-Members gain an understanding of communicating one's feelings honestly and directly paves the way to getting needs met. Becoming assertive builds autonomy and self confidence. Have members understand that as adults they have basic rights
- 4- Have women find a voice within connection

Preparation:

- Co-facilitator meeting to review information and roles
- Prepare handouts and flipchart information
- Prepare group space and refreshments/snacks

Materials:

- Flipchart stand and paper
- Nametags
- Markers, pens and paper
- Handouts #1-5 for Session #4

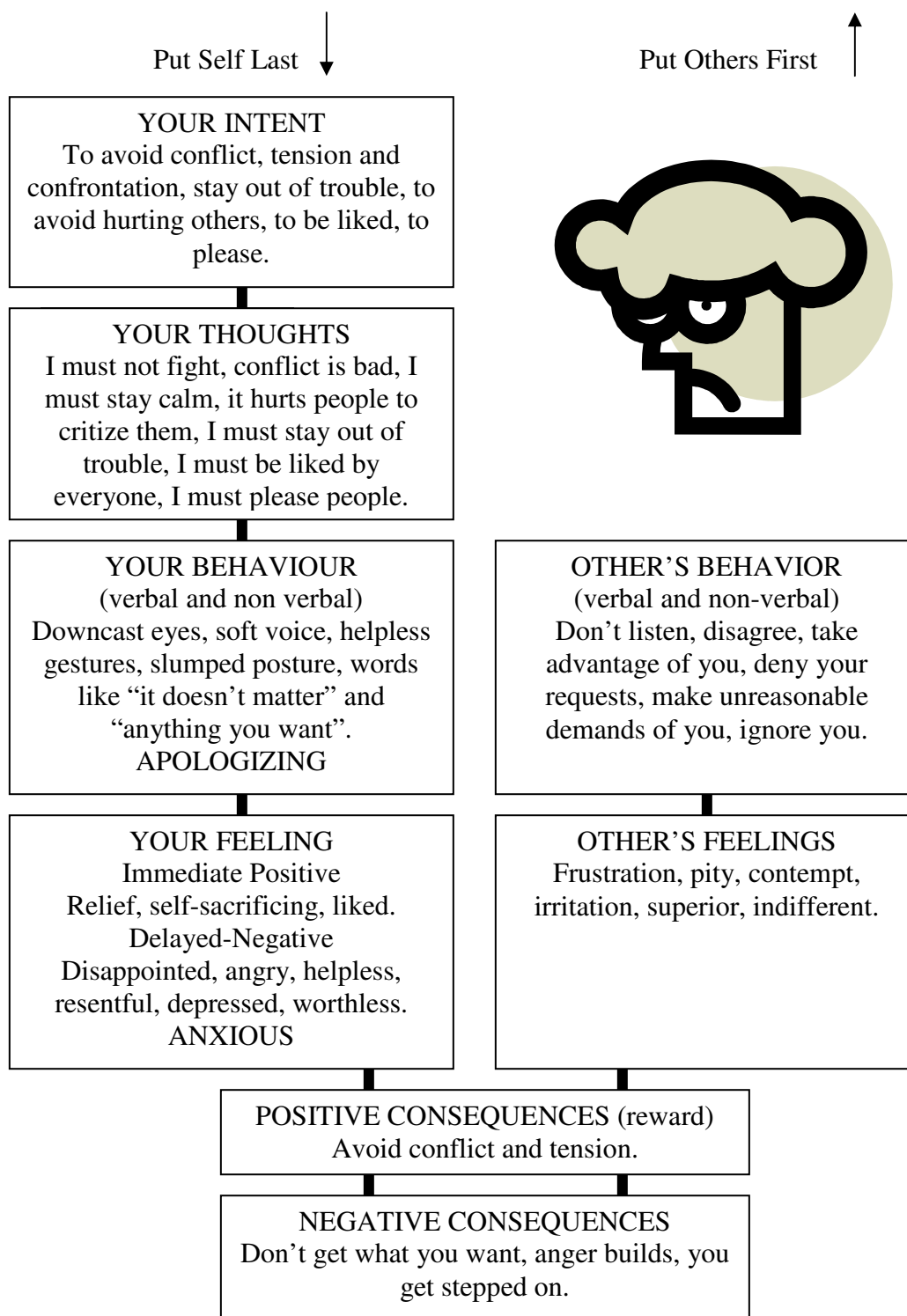
Topic & Time	Activity	Notes & Supplies
Check-In 15 min.	<ul style="list-style-type: none"> - Check-in to help members reconnect -Check-in with each member by identifying one thing they have learned from another member 	<ul style="list-style-type: none"> - Answer any questions that group members may have -address confidentiality -Provide each member the opportunity to see how they are feeling -Create atmosphere of connection to each member
Process last week 10 min.	<ul style="list-style-type: none"> - Discuss what stood out for members since last session and how they have applied their learning - Explore any questions or concerns that the group members may have from session 3 	<ul style="list-style-type: none"> Open discussion to the group - Build trust with sharing of experience - Facilitators support active listening and offer celebrations of learning
Assertiveness (Bourne, 2000, p.277 & p. 282) 20 min.	<ul style="list-style-type: none"> -Flip-chart discussion -Have group members identify differences in passive aggressive, aggressive, and assertive behaviour 	NEED: Flip-chart and felt

<p>How do you communicate? (Sachs, 1998) 10 min.</p>	<ul style="list-style-type: none"> - In triads, members to determine their dominant behavioural style (submissive, aggressive, passive, manipulative, and assertive) - If needed, have the group work in triads first and then facilitate a larger discussion afterwards -Facilitators support active listening 	
<p>Break 15 min.</p>	<ul style="list-style-type: none"> - Members to have a break and snack 	<p>Snack</p>
<p>Personal bill of rights (Bourne, 2000, p. 283) 15 min.</p>	<ul style="list-style-type: none"> - Members to share 5 rights that carry personal significance with the larger group 	<p>NEED: Handout #1, Session 5: Personal bill of rights for each member</p>
<p>Asserting yourself (Bourne, 2000, p.279) 15 min.</p>	<ul style="list-style-type: none"> - In small groups have each group brainstorm a scenario for passive and aggressive -Role play an assertive response to each scenario- take turns 	<p>Remind group of rules for discussion (being open and supportive of others)</p> <ul style="list-style-type: none"> -Create atmosphere of connection to each member and the experience of being women with a shared experiences - Encourage questions and comments from participants <p>Facilitators support active listening</p> <ul style="list-style-type: none"> -Practice assertion
<p>Dass-21 10 min.</p>	<ul style="list-style-type: none"> - Individually complete dass-21 	<p>NEED: handout #3, Session 5: Depression, anxiety, stress scale</p> <p>NOTE: Leaders to score and interpret and provide feedback to each member individually</p>
<p>Check-out and evaluation 15 min.</p>	<ul style="list-style-type: none"> - Draw symbol of current feeling -Share with group-Distribute evaluation for members to complete before leaving 	<ul style="list-style-type: none"> - Facilitators support active <p>NEED: handout #4, Session 4: Assessment of client satisfaction for each member</p>

Handout Number 1-Page 1, Session 4: Practice Assertion
 Bourne, E. (2000). *The anxiety and phobia workbook*. Oakland, CA: New Harbinger
 Publications, Inc.

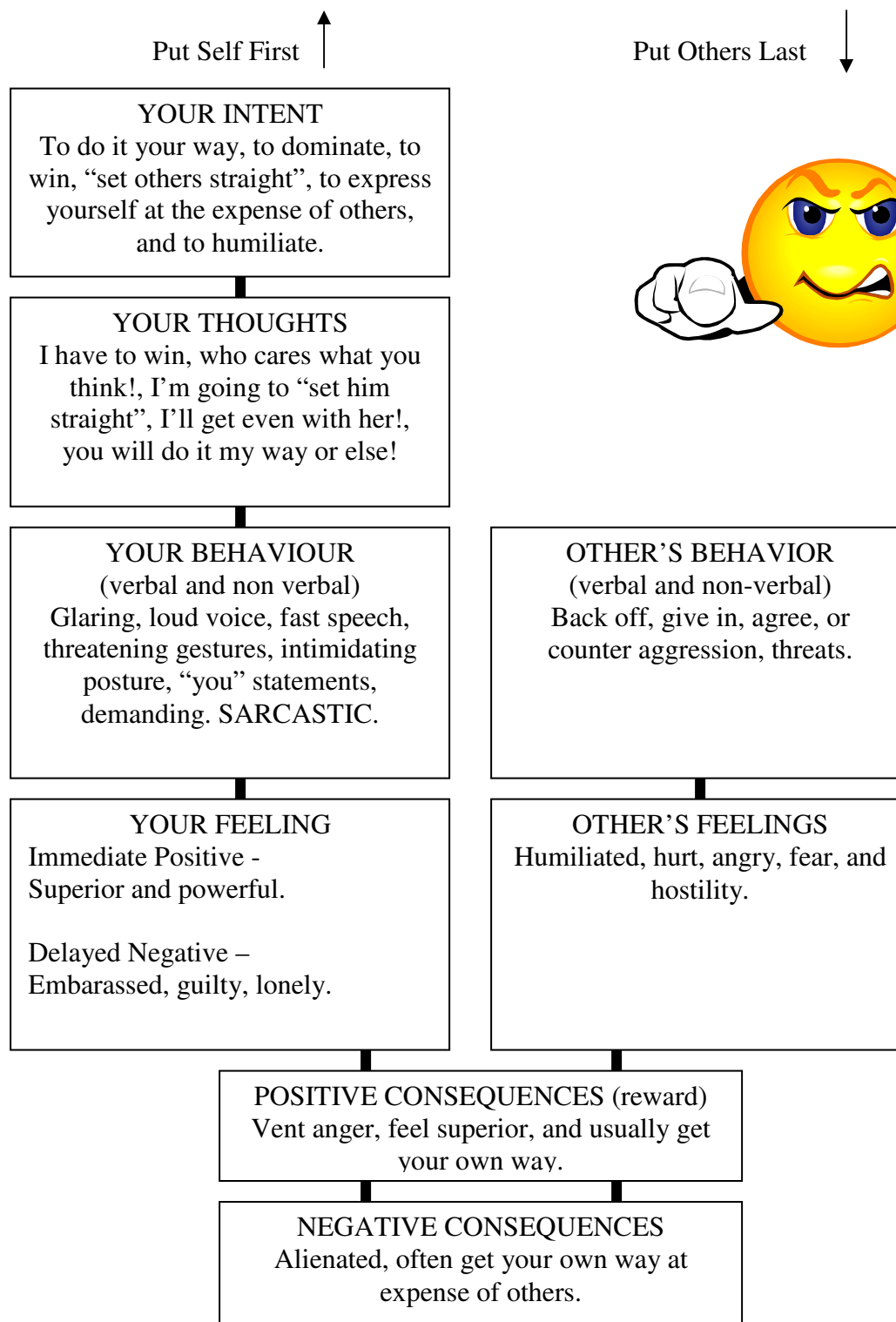
WHAT'S YOUR STYLE?

Communication – Passive



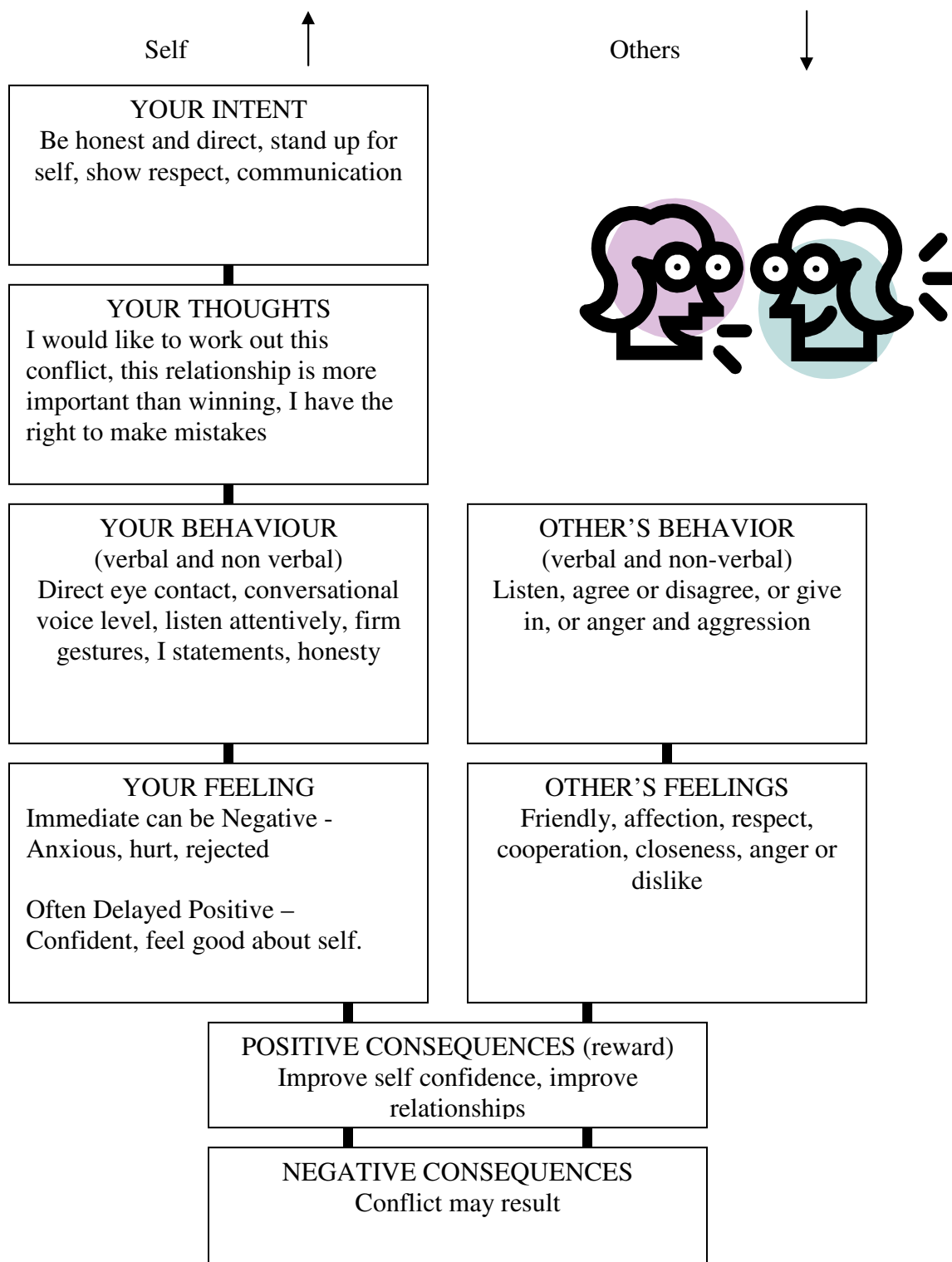
Handout Number 1-Page 2, Session 4: Practice Assertion
 Bourne, E. (2000). *The anxiety and phobia workbook*. Oakland, CA: New Harbinger
 Publications, Inc.

Communication – Aggressive



Handout Number 1-Page 3, Session 4: Practice Assertion
 Bourne, E. (2000). *The anxiety and phobia workbook*. Oakland, CA: New Harbinger
 Publications, Inc.

Communication – Assertive

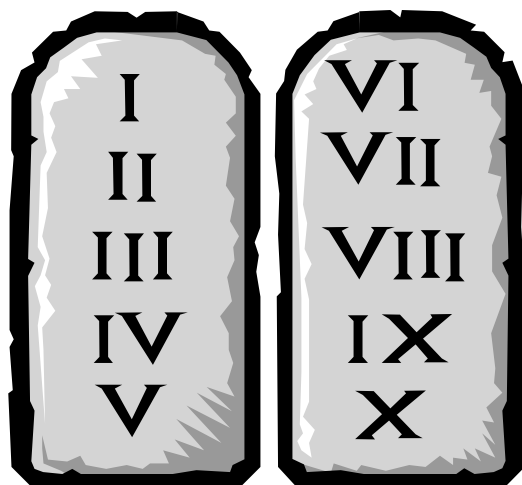


Handout Number 2, Session 4: Personal Bill of Rights
Bourne, E. (2000). *The anxiety and phobia workbook*. Oakland, CA: New Harbinger
Publications, Inc.

Personal Bill of Rights

As adult human beings we have certain rights. Either we have forgotten them or were never taught then as children. As an assertive individual you are entitled to have the right to all of the things in the Assertive Bill of Rights. In addition you also have the responsibility to exercise those rights. Take a look at the following list and determine your willingness to believe and exercise each right:

- I. You have the right to judge your own behaviour
- II. You have the right to offer no reasons or excuses to justify your behaviour
- III. You have the right to judge whether you are responsible for finding solutions to other people's problems
- IV. You have the right to change your mind
- V. You have the right to make mistakes
- VI. VI You have the right to say "I don't know"
- VII. You have the right to be independent of the goodwill of others before coping with them
- VIII. You have the right to be illogical in making decisions
- IX. You have the right to ask for what you want
- X. You have the right to express all of your feelings, positive and negative
- XI. I have the right to be playful and frivolous
- XII. I have the right to change and grow
- XIII. I have the right to be happy
- XIV. I have the right to be treated with dignity and respect



Handout Number 3, Session 4: Depression Anxiety Stress Scale 21

DASS21

Name:

Date:

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of time
- 3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (e.g., in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Antony, M.M., Bieling, P.J., Cox, B.J., Enns, M.W. & Swinson, R.P. (1998). Psychometric properties of the 42-item and 21-item versions of the Depression Anxiety Stress Scales (DASS) in clinical groups and a community sample. *Psychological Assessment*, 10, 176-181.

Handout Number 4, Session 4: Assessment of client progress

Assessment of Client Progress- Individual member (Weekly)

0 = Not at all **1** = Slightly **2** = Somewhat **3** = Pretty Much **4** = Very Much

NOTE: Please complete at the end of the session (5 minutes) and give assessment to one of the leaders.

As a result of tonight's group,

1) I Realized something new about myself	1	2	3	4
2) I am more aware of my feelings	1	2	3	4
3) I Felt my counsellor understands me	1	2	3	4
4) I Feel supported in the group	1	2	3	4
5) I feel comfortable in the group	1	2	3	4
6) I feel closer to my counsellor	1	2	3	4
7) I feel closer to my group members	1	2	3	4
8) I can explore personal feelings	1	2	3	4
9) I can express previously inhibited feelings	1	2	3	4
10) I feel hopeful	1	2	3	4
11) I accept myself	1	2	3	4

Adapted from the Group Counseling Helpful Impacts Scale in Kivlighan, D. M., Multon, K. D., & Brossart, D. F. (1996). Helpful impacts in group counseling: Development of a multidimensional rating system. *Journal of Counseling Psychology, 43*, 347-355.

Happy Moms and Happy Babes: A Group Program for Expectant Moms



Session 5 Plan:

Relaxation

Session #5: Relaxation and Preparation for Group Closure

Objectives:

- 1- Continue to build social support network among group members through sharing and relating to others in the group (mutual empathy and self empathy)
- 2-Examine the purpose of relaxation strategies in alleviating stress
- 3-Facilitate the process of diaphragmatic breathing for stress management
- 4- Examine and process barriers to alleviating stress
- 5-Examine termination of group and how each member is going to use the knowledge and experience of the group in everyday life
- 6- Emphasize support for the experience of women
- 7- To create increased ability of each member to continue to engage in mutually supportive relationships outside of group

Preparation:

- Co-facilitator meeting to review information and roles
- Prepare handouts and flipchart information
- Prepare group space and refreshments/snacks

Materials:

- Flipchart notes
- Name tags, markers, pens and paper
- Handouts #1-2 for Session #5

Topic & Time	Activity	Notes & Supplies
Check-In 15 min.	<ul style="list-style-type: none"> - Check-in to help members reconnect -Check-in with each member by identifying a colour that describes how they are feeling in the here and now 	<ul style="list-style-type: none"> - Answer any questions that group members may have (e.g., evaluations) -Address confidentiality -Provide each member the opportunity to see how they are feeling -Create atmosphere of connection to each member
Process last week 10 min.	<ul style="list-style-type: none"> - Discuss what stood out for members since session 4 and how they have applied their learning -What is needing extra attention 	<ul style="list-style-type: none"> Open discussion to the group - Build trust with sharing of experience - Facilitators support active listening and offer celebrations of learning
Your daily refuge (Wright, 1997) 10 min.	<ul style="list-style-type: none"> - In pairs, brainstorm safe places to relax and discuss what this safe place my look like 	<ul style="list-style-type: none"> Group leader shares what their relaxation room looks like (e.g., pale colours, candles, water fountain, aroma-therapy) felt

<p>Progressive muscle relaxation (Bourne, 2000, p.80-82) 20 min.</p>	<p>-Group leaders to facilitate discussion about progressive muscle relaxation -Identify steps -Group leaders model technique for members (behavioural rehearsal) - What does it feel like to breathe deeply? What do you feel in your body after having engaged in diaphragmatic breathing? How can you use this strategy to de-stress at in your life?</p>	<p>NEED: handout #1, session 5 Progressive muscle relaxation. -Note: handout to be given after leaders demo</p>
<p>Break 15 min.</p>	<p>- Members to have a break and snack</p>	<p>Snack</p>
<p>Progressive muscle relaxation 15 min.</p>	<p>- Members break into triads and take turns with behavioural rehearsals: Person 1 observer ; person 2 reader; person 3 participant</p>	<p>-Opportunity for group members to learn from each other</p>
<p>Termination 15 min.</p>	<p>- Group leaders facilitate discussion - 1. What would you like to take away from this group and use in your life? 2. How can you use others in the group as a source of support?</p>	<p>Remind group of rules for discussion (being open and supportive of others) -Create atmosphere of connection to each member and the experience of being women with a shared experiences - Encourage questions and comments from participants -Facilitators support active listening -Open it up to the group. -Talk about follow-up meeting - review group experience -Leaders to assist members in dealing with any feelings they have about termination</p>
<p>Check-out and evaluation 10 min.</p>	<p>- One feeling word check-out -Share with group-Distribute evaluation for members to complete before leaving</p>	<p>NEED: handout #2, Session 5: Assessment of client satisfaction for each member</p>
<p>Announcement 10 min.</p>	<p>- Share 1 resource in the community that may interest pregnant women (e.g., Parent child resources</p>	

Handout Number 1, Session 5: Progressive Muscle Relaxation
Bourne, E. (2000). *The anxiety and phobia workbook*. Oakland, CA: New Harbinger Publications, Inc.

There are many techniques available to help people relax, but you may not know how to concentrate on relaxing. What if you are so “geared up” that you are not even sure how it feels to relax? Progressive muscle relaxation is a technique that can help you actually feel the difference between tension and relaxation.

The Basic Technique

Progressive muscle relaxation is a three-step technique. First, you tense and muscle and notice how it feels; then, you release the tension and pay attention to that feeling; and finally, you concentrate on the difference between the two sensations. This exercise can be done while sitting or lying down and only takes about 15 minutes. It helps if you can practice the technique in a quiet relaxing atmosphere.



Example,

Tighten the muscles in your face; the notice how it feels. Your muscles are taut and strained. You may feel tension in your cheeks, chin, forehead, and eyes. Hold the tension for a few seconds before relaxing.

Release the tense muscles in your face and let the tensions slip away. You may notice that your face feels lighter than it did while your muscles were tensed, and you feel relieved of pressure.

Notice the difference between how your face felt when tensed, and how it felt when you released when you released the tension. Does your face feel tingly or warm when relaxed? Did the throbbing you felt when tense disappear when relaxed?

Progression of the Technique

It is helpful to try this technique on each of the major muscle groups on your body. The basic technique remains the same for each group: tighten the muscle, release the tension, and then notice the difference. You can start with your face, and then progress to other muscles, including the shoulders, arms, hands, chest, back, stomach, legs and feet.

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Handout Number 2, Session 5: Assessment of client progress

Assessment of Client Progress- Individual member (Weekly)

0 = Not at all **1** = Slightly **2** = Somewhat **3** = Pretty Much **4** = Very Much

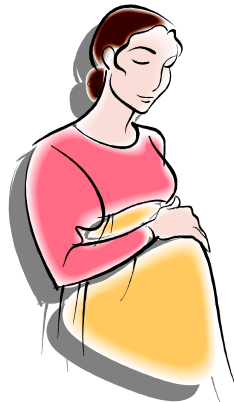
NOTE: Please complete at the end of the session (5 minutes) and give assessment to one of the leaders

As a result of tonight's group,

1) I Realized something new about myself	1	2	3	4
2) I am more aware of my feelings	1	2	3	4
3) I Felt my counsellor understands me	1	2	3	4
4) I Feel supported in the group	1	2	3	4
5) I feel comfortable in the group	1	2	3	4
6) I feel closer to my counsellor	1	2	3	4
7) I feel closer to my group members	1	2	3	4
8) I can explore personal feelings	1	2	3	4
9) I can express previously inhibited feelings	1	2	3	4
10) I feel hopeful	1	2	3	4
11) I accept myself	1	2	3	4

Adapted from the Group Counseling Helpful Impacts Scale in Kivlighan, D. M., Multon, K. D., & Brossart, D. F. (1996). Helpful impacts in group counseling: Development of a multidimensional rating system. *Journal of Counseling Psychology, 43*, 347-355.

**Happy Moms and Happy Babes:
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**Session 6 Plan:
Transitions and Saying Good-Bye**

Session #6: Transitions and Saying Good-Bye

Objectives:

- 1- Continue to build social support network among group members through sharing and relating to others in the group (mutual empathy and self empathy)
- 2-Examine termination of group and how each member is going to use the knowledge and experience of the group in everyday life
- 3- Emphasize support for the experience of women
- 4- To create increased ability of each member to continue to engage in mutually supportive relationships outside of group
- 5- Members work through feelings as the group comes to an end

Preparation:

- Co-facilitator meeting to review information and roles
- Prepare handouts and flipchart information
- Prepare group space and refreshments/snacks

Materials:

- Flipchart notes
- Name tags, markers, pens and paper
- Handouts #1-2 for Session #6

Topic & Time	Activity	Notes & Supplies
Check-In 15 min.	- Check-in to help members reconnect -Invite each member to identify a colour that describes how they are feeling in the here and now	- Answer any questions that group members may have (e.g., evaluations, termination) -Address confidentiality -Provide each member the opportunity to see how they are feeling -Create atmosphere of connection to each member
7 Techniques of Managing Stress 10 min.	- Examine the 7 techniques of managing stress and have each member comment on the step that has the most meaning to them	Open discussion to the group - Build trust with sharing of experience - Facilitators support active listening and offer celebrations of learning NEED: handout number 1, Session 6 for each member
Personal achievement 10 min.	- In pairs, each member discusses how they approached stress in the past and what they will do in the future. -What has motivated change	Encourage active listening and mutual support between members

	for each member?	
Break 15 min.	- Members to have a break and snack	Snack
Symbols of change 40 min. (10 minutes drawing and 30 minutes sharing with the group)	- Each member to draw the following on a piece of paper 1) Symbol of who they are 2) Symbol of what they want for their future 3) Symbol of what they want for their family	NEED: Paper for each member Have each member share their drawings with the larger group
Check-out, evaluation and Free time 20 min.	- One feeling word check-out -Share with group -Distribute evaluation for members to complete before leaving	NEED: handout #2, Session 6: Assessment of client satisfaction for each member Note: Last 10 minutes of session can be used by the members as free time to socialize with others as the group closes

7 Techniques of Managing Stress: COMFORT

- C- Challenge unhealthy beliefs**
- O- Open yourself up to others and get support**
- M- Make things happen**
- F- Find your balance**
- O- Observe yourself**
- R- Relax**
- T- Take responsibility**



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Handout Number 2, Session 6: Assessment of client progress

Assessment of Client Progress- Individual member (Weekly)

0 = Not at all **1** = Slightly **2** = Somewhat **3** = Pretty Much **4** = Very Much

NOTE: Please complete at the end of the session (5 minutes) and give assessment to one of the leaders

As a result of tonight's group,

1) I Realized something new about myself	1	2	3	4
2) I am more aware of my feelings	1	2	3	4
3) I Felt my counsellor understands me	1	2	3	4
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