A Group Model for Reducing Isolation in Pregnancy

Background

The paradox faced in community health is how to deliver more for less. How can population based services be effective in supporting women in their pregnancy? Outcomes of interest include the outcomes of the pregnancy including gestational age at term and appropriate birth weight and general wellbeing of the infant. In addition, we need to be concerned about the mother's potential to mother the newborn.

There is no other time in one's life when such an enormous role shift occurs as when you are responsible for a baby, whether you are the mother or father of the child born. Community health nurses have reported on the increasing amount of isolation they find when visiting families with newborns. Estrangement from families of origin both from geographical and psychological factors seems to be more common. Women often have little opportunity to meet friends in their community because they lack transportation or the neighborhood environment is not safe. Many women feel lonely due to lack of family and friends and even the absence of the baby's father. Many women encounter depression during the perinatal period, which dramatically influences their capacity to be a responsive nurturer of their infant.

Reducing isolation

The First Steps Maternity Support Program in the State of Washington set out to investigate ways to reduce the isolation of women in their First Steps program using a model of group interaction where they would have the opportunity to feel supported, happy and connected with the community. While most educational groups prioritize knowledge acquisition, a different model based on social interaction, experiential strength-based learning was sought. Fortunately a social scientist and social worker, Dr. Lynne Macdonald, has created such a model based on family systems, mental health, child development and strength-based learning called the FAST mode. Our consultation and training with the Macdonald FAST model gave us a very valuable framework on which to build our Washington State Group Model. Unfortunately we were not able to fully implement the FAST model due to restrictions about funding only the pregnant women and not other family members as the FAST model promotes.

We had the opportunity to work with very committed staff at the Washington State Department of Health and the Welfare Office in the Department of Health and Human Services. In particular **Sherilynne Casey** was a strong supporter of this group work. Although she retired from her leadership role with the First Steps Program, she set the course for this work to proceed. We want to acknowledge her spirit of inquiry and her passion for mothers and children. This report is dedicated to her.

Adapting the FAST model

In this report we have proceeded with the evidence for social support in addressing the outcomes of pregnancy and maternal mood. We also provide the lessons we learned in having our adaptation of the FAST model tested in First Steps programs in Pasco, Bremerton and Seattle. The staff in each program was brilliant and the satisfaction they

derived from implementing this program was impressive. They felt they reached the women in ways that had not been possible with other avenues of service delivery.

We have included the principles we derived for various elements of the group process including recruitment, role of the facilitator, group structure, group discussion, relaxation, weekly closing activity, saying goodbye and the case for simulating group discussion. Each of these principles is presented in the written text and available as a separate handout. The Webb site presentation is enhanced by actual pictures from the group at Pasco. Many thanks to the staff and clients at La Clinica in Pasco.

Social Support as a foundation for health

From the beginning of humankind, women have given birth to their babies with support from others. The ties of kinship and extended family assured the survival of offspring and the human family. Modern life, however, has interfered with the consistent provision of social support to women and children. Yet, the enduring belief in the contribution of social support to pregnancy and infant health compels the study and provision of it.

Social Support: Definition.

The term social support refers to a wide variety of functions provided by social relationships. Social support usually consists of three types of functions: emotional support, instrumental support and informational support. People feel emotional support when others listen, care, love and reassure. Instrumental support consists of concrete help, such as child care, money, household chores and transportation. Informational support refers to useful news, advice, guidance or ideas to solve problems or referrals to resources. A critical component of social support is whether an individual actually receives it, or only perceives its availability. Perception of the availability and delivery of social support has profound influence on the response to life events.

The composition of social support varies among people by stage in life, psychological comfort with relationships and gender. Some people are comfortable with human relationships, stemming from their success in establishing secure attachments especially during infancy. Other people have a knack for retaining relationships over a lifetime, so that the number of people providing social support continues to grow or does not wane in quality and quantity during the life span. In comparison to men, women tend to maintain more emotionally intimate relationships, mobilize more social support during periods of stress, and provide more frequent and more effective social support to others. Women may also experience more conflict with people who provide social support because of the inability to reciprocate or perception of meddling in personal affairs.

Function of Social Support: Research outcomes

Researchers offer two ways in which social support affects health. One method is through the main effect of social support on health (Cohen and Wills, 1985). The main effect model suggests that more social support yields better health and quality of life regardless of the amount of stress experienced. In this model social support has a direct effect on emotional states and neuroendocrine responses. A common source of social support for women is their husbands or partners. Research indicates that the father of the baby has a profound influence on the well-being of the pregnant woman. The involvement of the baby's father or husband influences the use of prenatal care and reduces stress, anxiety and depression in women. Zambrana, Scrimshaw, Dunkel-Scheter and Collins (1997) found that support from the baby's father was associated with significantly less stress, less substance abuse and more positive attitude towards the pregnancy.

The direct effect of social support during pregnancy is confirmed by Feldman, Dunkel-Scheter, Sandman and Wadhwa (2000). The prospective study had 247 mothers from

two university affiliated prenatal clinics. The majority (67%) of women were married; 52% were multiparaous; and the mean age was 26 years with a range of 18-40 years. Social support scales measured family support, baby's father support and interpersonal support (i.e., the availability of people to deal with personal problems). Findings from the study showed that all three types of support contributed cumulatively to predicting infant birth weight, after controlling for length of gestation. It is suggested that social support from all of these sources reduced the effect of stress, and enhanced positive health behavior. In a study of 2052 women, Glazier et al., (2004) found that those who reported higher levels of social support had lower reported experiences with negative life events during pregnancy.

Family support has a significant role in promoting the health of pregnant teens, more so than the father of the baby. In this situation, support from the father of the baby wanes as the pregnancy progresses. Teenagers who reported higher levels of family support had babies with higher birth weight and experienced less postpartum depression. Boyce, Schaefer and Utti (1985) showed that pregnant teenagers who reported having helpful families had fewer neonatal complications.

Social support may also work through stress-buffering, where social support protects an individual from the effect of stress. The availability of social support influences the appraisal of demands and adaptive capacities. When there is little stress, social support has no effect on health, but under conditions of high stress, social support is protective. Evidence of the stress-buffering effect of social support on pregnancy outcome, however, is mixed. In landmark work, Nuckolls et al. (1972) showed that life stress and social support interacted, where high stress women who had high social support had fewer complications, although there was no effect of social support in low stress women.

The providers of social support do not always bear good will; they can also generate stress and harm. Epidemiological data indicates that the prevalence of violence during pregnancy ranges from 9 to 20 percent (Gazmararian 1996). Gazmararian et al. (1995) showed that women in all socioeconomic groups with unwanted pregnancies had 4.1 times the odds of experiencing physical violence compared to women with pregnancies that were wanted. While physical violence is the extreme of interpersonal conflict, milder forms have erosive effect. Cramer and McDonald (1996) interviewed 42 young low-income mothers who reported that, although families provided help with childrearing, such support was riddled with angst, including criticism, intrusiveness, conflict and disappointment. Clemmens (2000) also found that long term co-residence of the teen mother with her own mother may breed conflict, which had a negative impact on the quality of the home environment for the child.

Influencing health outcome of pregnancy and women in the postpartum period by providing social support has also been the goal of research. Hodnett and Fredricks (2003) conducted an analysis of 16 randomized trials that tested the effect of additional support by professional or lay persons to women at risk for having a preterm and/or growth-restricted babies. Social support was defined as some form of emotional support (e.g., counseling reassurance, sympathetic listening) with or without additional information/advice, occurring during home visits, clinic appointments or telephone calls.

Additional support also included tangible assistance, such as transportation or child care. Findings showed that additional support was unlikely to prevent low birth weight or preterm babies, but may be helpful in reducing the likelihood of caesarean birth.

Doulas and health care providers

The doula has been found to be an effective source of support during labor and delivery. A doula is someone who is in- service to the woman during labor and provides support, comfort and information to the mother and her partner who may not be able to fully attend to the mother's needs and cope with personal experiences. The doula is effective in reducing pain, anxiety and fear in the laboring couple. The presence of the doula decreases the use of analgesia and oxytocin, shortens the length of labor and decreases operative births.

Another set of studies has focused on influencing the adjustment of women during the postpartum period by providing formal interventions through health care providers. Dennis and Creedy (2004) conducted a comprehensive review of psychosocial and psychological interventions aimed at preventing postpartum depression. The review involved 15 studies that enrolled 7600 women. Types of psychosocial interventions were antenatal and postnatal classes (Brugha 2000; Reid 2002; Stamp 1995), lay home visits (Morrell 2000), continuity of care (Waldenstrom 2000), and early postpartum visits delivered by nurses, midwives, physicians or allied health care providers. Psychological interventions involved debriefing and interpersonal psychotherapy by midwives, nurses or mental health professionals. In the analysis, Dennis and Creedy found no effect of psychosocial interventions and psychological interventions, except for home visits by health professionals. The analysis also showed that interventions that started in postpartrum, offered multiple contacts, and targeted 'at risk' women reduced depression symptoms. Furthermore, Dennis and Creedy (2004) stated that the analysis revealed no evidence to support the use of antenatal group interventions to heterogeneous samples of women 'at risk' for developing postpartum depression. They recommended research on structured interventions with homogenous, symptomatic women.

Providing prenatal and postpartum social support to women: A different way of thinking

The literature on social support indicates that intimacy, access to resources and information promote the health of women during prenatal and postpartum periods. A responsive partner or husband has the most effect on the health of women. Families are important sources of social support, and selected interventions by professionals are effective. Preponderance of evidence from randomized clinical trials indicate that social support provided in the form of professional interventions does not have strong effect on pregnancy outcome and the reduction of postpartum depression. Professional programs to prevent low birth weight babies involve a variety of strategies, including clinic visits, home visits, telephone contact, individualized counseling, and instruction booklets. Support programs to reduce postnatal depression typically involve interpersonal psychotherapy, debriefing, follow-up physician visits, self-help materials, educational problem-solving, and weekly support groups for emotional support and preparation for parenthood meetings. These methods, though well-intentioned forms of support, may not

be the type of content and method of support that benefit pregnant women and new mothers.

What might benefit women are experiences that provide a network of social relationships to help them adapt. Episodic contacts with a health provider at the clinic or home visit may be comforting at that moment in time, but someone to call at all other times might be more comforting. Women rely on a group of providers, family and friends to assist their transition. The absence of a supportive group in the face of doubt, conflict and stress may breed ill health in the mother and baby. When women are stressed, they cope by talking and relating to others.

Social support groups provide opportunities for women to meet other women, share their experiences, learn from each other, and develop sustainable social relationships (Aston, 2002)

The goal of developing relationships through group work is exemplified by the work of Dr. Lynn MacDonald who created the program, Families and Schools Together (FAST). It is designed to strengthen families while helping parents connect with their children's schools. Dr. MacDonald uses the family systems model as a basic framework, and has incorporated evidence-based processes to enhance communication between adult partners in a family, and between parents and children. For example, each family creates a family flag to identify it as unique from others, or the designated head of the family receives information to give to other family members in order to affirm his or her role in the family. FAST programs are successful in improving family relationships and school success in children. The FAST method has been so successful that programs have been developed for families with teenagers, middle-school children and those in elementary school.

Dr. MacDonald's most recent venture is developing "Baby Fast." It is designed to reduce isolation, conflict and stress to promote the development of infants with teen parents. The program promotes multigenerational relationships between teen parenst and grandmothers, and the interaction between the teen parent and infant. Group processes engage both parties to bring them emotionally closer together through shared family activities, intergenerational group discussions, and separate group time for only grandmothers, and for teen parents with their infants.

The desire to apply group processes from Baby Fast to reducing social isolation was a goal of the First Step administrators of the State of Washington, Department of Health. For over a decade First Steps provided predominantly one-to-one services to pregnant women on Medicaid to promote healthy outcome. However, changes in funding forced changes in the delivery of program services from focusing on individual care to group services for pregnant women on Medicaid. Funding regulations, moreover, precluded an intergenerational approach and the family systems approach promoted by Dr. Lynn MacDonald.

Since the relationship-building techniques from Baby Fast were effective in promoting relationships between teen mothers and their own mothers, it was surmised that the strategies could be used with only pregnant women to facilitate group support and friendships. Principles and methods from Baby FAST were taught to staff from three agencies in Washington State communities: Bremerton-Kitsap, Pasco, and the University of Washington Medical Center. Staff incorporated the techniques at their own discretion to create support groups for Medicaid pregnant women in their respective communities.

Principles and framework

An important principle that guides group development is the notion of meaning-making. The concept of meaning-making comes from a theory of learning called constructivism. The premise of constructivism is that people learn by building on what they know from experiences, existing understanding and new ideas presented to them. The learner makes meaning by interpreting new experiences and transforms prior knowledge. The transformation of new experiences involves the entire brain, both the cortex, the higher centers of thinking and learning, and the "lower brain," or the limbic system. The limbic system attaches an emotional tone to the information, and sends it to the cortex. Depending on the meaning of the information, the brain generates additional signals for appropriate responses. The limbic system dispatches signals of excitement and engagement with positively interpreted information. Negative or threatening information disengages attention or causes aversive behavior. The limbic system's interpretation of sensory information is based on memories and immediate reaction to a current event. In terms of learning, anxiety, depression, anger or frustration can promote self-defeating patterns, prevent learning and stunt mental/emotional growth. In contrast, the more positive a learner's memories and reaction to the event, the better the learning will be. Happiness has a positive effect on learning, memory and social behavior. Thus, learning and emotions are intricately entwined.

Creating respectful and happy environments

It might be considered revolutionary to focus on creating "happy" environments for pregnant women, especially for those who are adolescents, poor or experiencing stressful living conditions. Most often support groups for these women focus on their problems, or use a health education format. In either case, sole focus on problems or education devoid of joy may interfere with learning new ideas or behavior. The objective, instead, is to create environments that engage, motivate, create joy, and build on personal knowledge to foster positive meaning-making, refreshing ways of thinking, new ways of behaving, and establishing more social connections. Positive experiences produce "feel good" neurochemials. Serotonin is increased with praise, encouragement, positive touch, increase in social status and increase in social connections. Dopamine is increased with reward for doing a good job. Norepinephrine increases when things are fun, when strengths are reinforced and when people are involved. The following are different ways to create respectful and happy environments in support groups that are derived from Dr. Lynn MacDonald's, Baby FAST program.

Ambience. It's important to create a welcoming physical environment in a support group for pregnant women. Too often, support groups for poor or teen mothers occur in back rooms of public health departments, drab community rooms, or sterile conference rooms of medical centers or hospitals. A whiff of baby powder, pictures of beautiful babies, balloons, and charming table-top decorations all create a warm positive environment. The theme of the group might decorate a wall, such as "For the Sake of the Baby."

Group Routine. A routine in conducting a support group provides structure or an established procedure in the occurrence of group activities. For women whose lives are chaotic or riddled with crisis, a meeting routine may provide comfort and calm. If a sequence of events unfolds as expected, the women are more likely to develop trust. The more actions match words, the more trust the women will have. Trust builds confidence for more effective learning. According to Dr. Lynn MacDonald, trust begins to develop after six sequential encounters.

Trust. The most basic way to establish trust is making sure that the facilitators of the group do what they say they are going to do. It's helpful if facilitators practice the art of facilitation, and promote group work, rather than lecturing or educating. Respectful group work promotes open communication and promotes trust. Communication begins as people get to know one another. Trust grows as people talk and share information about themselves. When people are comfortable in a group they will begin to take the risks to share personal ideas. Familiarity between people might lead to friendships that flourish outside group experiences.

Studies have shown that people develop friendships with others based on similarity of experiences. Friendships are more likely to develop when people come in contact with others on a regular basis in their neighborhood, at social gatherings or at work. Friendships may grow when both parties see in the other physical attractiveness, social skills and responsiveness. Interactions with others who are similar validates people's views and confirm that they are correct in their thinking. As people reveal more about themselves, self-disclosure increases in depth and develops trust. Women's conversations focus on relationships, men and needs or feelings. An additional feature of friendships is sharing fun and relaxation together. Interactions with friends are more relaxed, friendly and involve more informal language that includes joking and teasing. Spending time together, mutual support and self-disclosure all contribute to maintenance of friendships.

Repetition. Throughout the FAST program developed by Dr. Lynn MacDonald, activities, sayings or meeting mantras are repeated. In traditional health education classes or support groups, there might be a new idea introduced every week, and they may not build on what participants know. Participants may leave feeling that a lot has been discussed but none may actually register in long-term memory. Repetition of sayings laden with positive emotional meaning may be remembered and secured in the recesses of the mind, and frame what people do. Dr. MacDonald emphasizes that sayings should be repeated at least 300 times throughout an eight-week session in order to firmly entrench the idea by changing brain dendrites and synapses. She uses the phrase, "For the

sake of the baby" to engrain the idea that what is done is done for the sake of the baby whether it is eating nutritious food, getting prenatal care, walking for exercise or making baby gifts.

Experiential Learning. Paulo Friere, a Brazilian educator, engaged impoverished and illiterate peasants in experiential learning to teach them to read. The people drew pictures of their environments, and from discussions about their pictures identified words that contained the sounds of Portuguese, the language of Brazil. By connecting sounds to letters, the people learned to read. Through this method, the people also developed conscientization or the awareness of their living conditions to act upon it. Conscientization is related to empowerment, to learning processes in which people create, share knowledge, tools and techniques to change and improve the quality of their lives and society. Through experiential learning people find meaning in the lessons and new ways of approaching life.

One way to promote experiential learning is through case scenarios that portray problems that women might encounter. Women have many concerns during pregnancy, but ones that might be foremost are concerns about the health of the baby, body changes, sleep, weight gain, aches and pains, sex during pregnancy, and other issues involving their partners.

During the postpartum period, common issues are stressful life events in general, marital conflict, and absence of support from spouse, family and friends. Actual issues to address in case scenarios may be generated by the mothers themselves. Group participants discuss how the woman in the scenario can solve her problem. If participants are not comfortable with case scenarios, then role playing is an alternative. The goal is to engage participants in discussion. They will use their own personal knowledge to understand what is going on or come up with solutions. The collective approach engages participants as a group to share ideas and multiple approaches. They learn that they have ideas of value and worth, increasing their confidence in their own ideas. By practicing in a safe group environment in which ideas are respected, participants learn that they have wisdom. Some women may not contribute but they do listen to their peers. Ideas coupled with feelings of efficacy may be recalled for action.

To create small group scenarios, there are a few basic ideas to keep in mind. Scenarios should come from the lives of the women living in the community. It's important that the women can relate to the story. The characters should be composites of women to assure anonymity. To stimulate discussion, the scenarios should have tension or conflict. There is no answer, since the goal is to stimulate discussion.

Choice Activities. William Glasser, MD is the author of Choice Theory that explains living as choices made to satisfy five basic needs: survival, love, freedom, fun and power. The most basic need is love and belonging. The fulfillment of these needs is satisfied in a person's own quality world comprised of people, things and beliefs. It is the picture of one's world. That quality world frames the kinds of choices people make. Glasser contends that the exercise of choice is expressed in ways a person behaves, thinks, feels,

and his or her physiological processes associated with what is done. For example, Glasser would say a pregnant teen might long for her ex-boyfriend who is part of her quality world. She pines for him, and chooses to feel that life is not worth living without him. Her appetite becomes depressed; she looses weight and lethargy overcomes her. Glasser, however, would also say that the young woman could choose to push her ex-boyfriend out of her quality world, give the baby a prominent place, and choose to take care of herself for the "sake of the baby." Both choices are creative, but one harms and the other liberates and nurtures growth.

In Baby Fast, Dr. Lynn MacDonald created Choice Activities. The overall goal of Choice Activities is to create opportunities for mothers to make choices and describe reasons for their choices in a safe environment.

One type of choice activity involves a tray with a variety of objects, such as small plastic animal, a ring, a miniature car, a pill box, a paper fan, keys, etc. Each mother chooses an object and tells others in the group what she picked and why. It helps to reveal who she is, builds connections, and creates individualism. The description often mirrors the mother's quality world. The exercise also helps to satisfy some basic fundamental needs: desire for fun, love, belonging, and freedom.

The second type of Choice Activity involves constructing something for the "sake of the baby." In this weekly activity, exercises focus the mother's attention on the baby, so he or she takes a prominent part in the mother's quality world. In each activity, the mother makes a gift for the sake of the baby. She tells another mother what she made and why. Mothers are able to express their creativity, and explanations help them to demonstrate their judgment. Others listen without judgment, and give praise for individual choices for the sake of the baby. The mothers witness another's process of making good choices and expressing love for the baby. The outcome is an increase in self-esteem from the exercise of repeatedly expressing their judgments, experiencing the respect for their uniqueness and having others listen to their ideas. Each object made is available for mothers to take home. Items do not have great monetary value; rather the value is in the meaning attributed to the object and choices made. Repetition of such positive experiences becomes engrained in the brain. Happiness has a positive effect on learning, memory and social behavior. A few examples, of choice activities are:

- Flower pot: Mothers make a flower pot from tiny artificial flowers poked into modeling clay nested in a small clay pot.
- Gift box: Glitter, stickers, ribbon cover a small wooden box that contains a message to the baby.
- Family album or picture: Participants create a family portrait or family album to tell the new baby about his or her own family.
- Diaper baby: Glitter or colored felt tip pens are used to drawn on canvas diaper bags to carry things for the baby.
- Baby t-shirt, bib, bath blanket or diaper bag: Colored markers are used to decorate these items.

Table based coaching. A life of poverty, oppression, and being a teen mother often does not bring respect from society. Experiences of common courtesy and grace are too often

far and between. One way of communicating respect is through table-based coaching. According to Dr. Lynn MacDonald, table-based coaching involves giving personal or one-to-one directions to each parent. For example, instruction to resume the group circle is given to each mother rather than shouting that it's time to get together again. Another example is each mother is instructed quietly that there is one more minute to work on the craft. Personal instruction creates clarity in communication, minimizes confusion, improves interaction and indicates regard for the parent.

Music. Research suggests that music stimulates the body's natural "feel good" chemicals (opiates and endorphins). Everyone singing together gets them into a positive mood that is a change from the stresses of daily life. This stimulation results in improved blood flow, blood pressure, pulse rate, breathing, and posture changes. Music gives a positive energy charge. Singing together builds affiliation. Singing songs from childhood, or teaching mothers songs helps build the repertoire of activities they can do with their babies. Singing each time the group meets also builds ritual, repetition and routine that sets in expectations and trust.

Relaxation. Mothers are divided into pairs, and each massages the hands of the other with permission. If they prefer to relax on their own they may use effleurage on themselves or engage in progressive relaxation.

Movement or Exercise. Walking 20-30 minutes three times a week is recommended during pregnancy as long as the woman does not have high blood pressure, early labor, rupture of members, loose cervix, multiple fetus, medically underweight fetus or persistent bleeding.

Lottery. Dr Richard Barth (1984) reviewed the literature on how to optimize attendance of hard-to-reach families in parenting programs. Cash, small prizes and vouchers have been used. A substantial, randomly awarded and guaranteed prize has significant effect on facilitating the attendance of hard-to-reach families. The weekly lottery involves a bountiful basket of things for the baby and mother. It should be a variety of items, such as a baby blanket, diapers, powder, t-shirts and layettes, as well as something for the mother, such as bath oils or even food. Each basket should be different in content. All mothers in the group are told that they will win the lottery but they do not know when. The anticipation of winning helps mothers feel that they deserve good things to happen to them and experience that life can bring good things. Each mother wins only once. Names are drawn from a "hat' without replacement which means once a mother wins her name is removed from the 'hat'. Much fanfare surrounds the drawing of the winning ticket with hoots, hollers and drum rolls. The mother who wins is showcased as the winning mother. The mother who wins knows that she is also expected to help with the snack, meal or crafts the following week. The built-in reciprocity of exchange is one way that the 'winning' mother can give back to the group for her good tidings. The notion of 'giving back' is based on Carl Dunst's (1988) notion of the universal cultural rule of reciprocity – if you receive, you want to give back. No one feels dignified about themselves if they only receive. Being able to give back helps to develop esteem in participants. In addition,

mothers are perceived as worthy and responsible to return the following week to help the group.

Sharing a Meal. Eating together is an opportunity for people to get to know each other. It's a time to share ideas, conversation and feel good. Eating together can inspire and strengthen bonds between people. Eating with others might bring back memories of eating with family and culture. For some people, eating reminds them of not having enough food, family fights and silence around the table, or eating alone. Sharing a meal in a group can build on positive memories of eating with family, or it can introduce a new way of being together while eating. Helping to prepare the meal is one way that group members can help to reciprocate the good tidings received from others in the group.

Recruitment

One of the challenges in conducting a social support group is recruiting participants. Some people join groups readily, others are hesitant, and still others will not attend at all. Here are a few ideas to keep in mind when recruiting participants:

Characteristics of the participants
Who are they? Age, ethnicity, primary language or health condition, concern or need
Do they have experience in attending groups?

Barriers to participation
Is the site accessible by public transportation or is private transportation necessary?
Are there child care issues?
Are there gate keepers to attendance?
What time of day is best to meet? How long is the meeting?
Is there a cost for attendance?
Are there other groups that offer similar services?

Awareness building
What are they ways in which prospective participants get information?
What are multiple-sensory ways for advertising, such as flyers, radio or oral communication?

Bridging techniques
Who endorses the social support group and are they trustworthy?
Should group staff or volunteers make personal contact by telephone or home visiting?
Can persons other than the target participants attend?

Incentives
What might be acceptable incentives: food, friends, fun or free gifts?
What topics might engage the interest of the participants?

Role of the Facilitator

The facilitator…

- Remains neutral and impartial
- Clarifies information
- Protects individuals and their ideas from attack
- Helps people listen to each other and share discussion.
- Accepts emotion and feelings; helps channel hostility, resistance and competition into productive discussion;
- Keeps the group focused on a common task and avoids side-tracking.
- Helps avoid repetition.
- Paces (speeds up or slows down discussion)
- Assures all points of view are expressed and understood.
- Clarifies areas of agreement and disagreement.
- Summarizes and checks for completion of each agenda item.
- Suggests alternative discussion methods if something is not working.
- Helps the group find win/win solutions or reach consensus or compromise as appropriate.

- Helps maintain a sense of humor.
- Deals with problems such as interrupters, people who monopolize, and late-comers
- Works with a recorder. Assures that all comments are recoded in some way.
- Brings meeting to closure.

Organizing the Mothers' Group meeting

The mother's group meeting process embraces the philosophy of creating an environment of respect and trust for experiential learning. It promotes positive emotions and positive meaning-making messages to develop friendships for the sake of the baby.

Event	Type of Group	Time – 2 Hours, 15 Minutes
Welcome	Everyone	5 min
Choices Activity	Small Group	20 min.
Updates and Hello	Everyone	10 min
Sharing of Choices	Pairs	10 min
Relaxation or Movement	Everyone in Large Group or in Pairs	20 min
Case Scenario	Small Group	30 min
Snack and Lottery	Everyone	30 min
Closing – Music or Group Activity	Everyone	10 min

Guidelines for Group Discussion

Sit in groups of 4-5 participants (minimum 3, maximum 8)

- Participants must be non-related.
- Select one case scenario to discuss at each table.
- Devote 30 minutes (maximum 45) to discussing a scenario

  Everyone gets a chance to be heard using either round style or free style. In the beginning, it's important to respect those participants might be shy or reluctant to contribute. They may contribute when they trust that they will be given a chance to speak. The facilitator should pay attention to cues to open up the discussion space for people to speak, monitor the contribution of others by inviting them to speak, or gently act as a conversation traffic manager.

- The goal is to discuss the topics, not to find a solution.
- Questions that need clarification and information about community services may be offered by team members at the next meeting.

Discussion Rules

Each person can participate, including asking questions, or giving an opinion, information or idea.

Others may build on each the responses of others.

No criticism is allowed. No ideas are bad or wrong.

Suggestions

Keep group structure together for at least 6 weeks, since it takes about 6 weeks to develop a new friend.

Small groups should have the same membership to build friendships and personal connections.

If new members join the program, start a new group of 4-8 rather than adding the new members to a established, bonded group.

If there seems to be an un-resolvable problem at the table, the team can remove the participant and shift them to another new group. Groups can become smaller and remain cohesive but not bigger.

Team member role is to assist in facilitating stagnant conversations and diffusing conflict. However, it is not an opportunity to teach, lecture, do therapy or critique opinions, or to exert power as a professional or agency staff.

Relaxation Techniques

Progressive Muscular Relaxation Technique

Sit comfortably, close the eyes and breathe naturally.

Clench the fists tightly and then tense the arms. Breathe out, release the tension in the arms all the way down to the fingertips.

Say the word 'relax'.

Let the arms fall to your side, like a limp doll. Relax the feet and calf muscles, then the thighs, bottom, stomach, back and head.

Tense the muscles of the face last and with each breath out say the word 'relax' so the entire body feels heavy and relaxed.

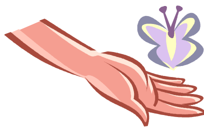
Imagine a peaceful scene and put yourself there. It may be a boat on a calm ocean or a beautiful clearing in the bush.

Stay there for a while.

Slowly arouse the feet, legs, back, and shoulders. Bring the arms forward into the lap, bring the head up, and open the eyes.

Effleurage

Gentle strokes of circular massage done with the fingertips, to be used on the abdomen, hips, thighs, or anywhere on the body where it feels good.



Use a flat-hand stroke on the arms, legs and broad flat surface of the back.

Effleurage with only the fingertips gliding (rather than the whole hand) is called feathering.

Light effleurage promotes relaxation, alleviates pain and encourages sleep. Relaxed muscles short-circuit fear, tension and pain.

Relaxation through Breathing

Inhale and exhale slowly through the nose only.

Then, inhale through the mouth with the lips puckered as if to kiss or making a whistle.

After the inhalation, relax the lips and exhale through the mouth slowly, then inhale through the nose and exhale through the mouth.

Last breath pattern is inhaling through the puckered lips and exhaling through the nose.

Sample Case Scenario

19- year- old Laura wants to attend a Thursday night class at the local community college. She has a 16-month-old child with a previous boyfriend and is currently five months pregnant with her new boyfriend's baby.

If she completes this class, she will receive her general secretary and receptionist certificate. Both her mom and Laura's new boyfriend support her, however both Mom and the boyfriend are out on Thursday nights, having a standing "girls night out' and "poker league".

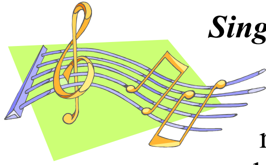
Laura wanted to ask either one to provide childcare, but yet has only hinted how important this class is to her. It's now the night before the class and neither Mom nor her boyfriend have volunteered to sit for Laura's child.

She thinks neither one of them really cares about her future or her and gets angry with them.

Share your ideas, thoughts and opinions.

Closing Activity

Bringing closure to the day's meeting helps with the transition from participating as a group member to leaving the group to resume life as an individual. Select an activity that the group wants or use the ideas listed below.



Sing a theme song of the group, selected by members, and sing it at the end of every meeting. Singing the song at the end of the meeting establishes a ritual that is expected to happen each time. Positive rituals create long lasting memories. Mothers might remember the song and then sing it to their babies.

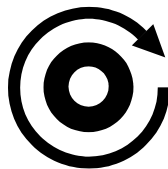
Do a group activity, such as **Rain**, where the members do the following motions in sequence to mimic sunshine and rain.

The facilitator begins with ***arms above the head with fingers touching to form an "O"*** to mimic the sun, and turns to the person on the right. Each person does the until the gesture reaches the facilitator.

Then, the facilitator ***snaps her fingers*** *to mimic drizzle*, turning to the person on the right and around the circle it goes.

The facilitator ***claps her hands*** *to mimic* heavy rain.

The facilitator ***pounds*** **the table** to mimic pouring heavy rain



The facilitator ***reverses*** the process, starting with hand clapping, finger snapping, and forming an "O" to mimic the return of sunshine

The facilitator, then says parting words, such as, "***Thank you every one for coming*. *We will see each other next week!"***

Saying Good Bye

For some people saying “good bye” at the end of a series of group meetings is hard. It’s important to tell people in a clear way that the group will meet for only a certain number of meetings. When there are two meetings remaining, gently remind the attendees that few meetings are left. The anticipatory guidance helps people cope with saying good bye.

The agency may or may not offer follow-up groups or booster sessions. It’s important to communicate what other classes or meetings are available at the agency or in the community. Some people may have established relationships with each other, so they will continue to meet outside of the group. Others may formalize their informal group so that it takes on a life of its’ own.

To see a Power Point presentation about one group’s experience using this model, click here.