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cognitive-behavioral methods embedded in feminist theory : a
project based upon an investigation at MotherWoman, Inc.,
Amherst, Massachusetts**

Leslie Ann Lauf
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Leslie A. Lauf
(MotherWoman, Inc.,
Amherst, MA)
Postpartum Depression Support
Group of MotherWoman, Inc.:
Cognitive-behavioral methods
embedded in feminist theory

ABSTRACT

The research reported in this paper was undertaken to examine and evaluate the usefulness of a particular support group for mothers suffering symptoms of postpartum depression (PPD). The new DSM-V, scheduled for release in 2013, will reflect some changes in our understanding of this affliction, including an extension of the onset time period of symptoms. Broadening the diagnostic criteria has implications for both screening and treatment. Literature on treatment tells us that this population of mothers is underserved, due to lack of access to treatment and/or poor diagnostic screening and detection of PPD. MotherWoman, Inc. is a non-profit organization in western Massachusetts that created a support group model, currently conducts weekly groups in four locations, and trains facilitators to administer their expanding program. Six mothers with self-reported symptoms of PPD, and who had attended six or more sessions of the group during their first year postpartum participated in a focus group, which provided the data for this research study.

Results of the research helped define the distinct format of the group and its value to participants. Data revealed that feminist psychology and cognitive behavioral theory were working together to create a supportive and healing atmosphere. It was also

indicated that the principles and guidelines governing this group were perceived as valuable and unique from the participants' experiences outside of the treatment milieu.

POSTPARTUM DEPRESSION SUPPORT GROUP OF MOTHERWOMAN, INC.:

COGNITIVE-BEHAVIORAL METHODS

EMBEDDED IN FEMINIST THEORY

A project based upon an investigation at
MotherWoman, Inc., Amherst, Massachusetts,
submitted in partial fulfillment of the requirement for
the degree of Master of Social Work.

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2011

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS.....	ii
TABLE OF CONTENTS	iii
CHAPTER	
I. INTRODUCTION.....	1
II. LITERATURE REVIEW.....	3
III. METHODOLOGY.....	20
IV. FINDINGS.....	25
V. CONCLUSION.....	39
REFERENCES	43
APPENDICES	
Appendix A: HSR Approval Letter.....	48
Appendix B: Agency Letter of Consent	49
Appendix C: Recruitment Letter.....	50
Appendix D: Informed Consent Form.....	51
Appendix E: PPD Support Group Principles of MotherWoman, Inc.....	53
Appendix F: PPD Support Group Guidelines of MotherWoman, Inc.....	54

CHAPTER I

INTRODUCTION

A simple internet search for “postpartum depression blogs” yields hundreds of thousands of results. Perhaps this nearly instantaneous connection to other mothers suffering from postpartum depression (PPD) provides much needed, and potentially anonymous, support to the estimated 10-33% of new mothers who experience it (Abrams & Curran, 2007; Klier, Muzik, Rosenblum, and Lenz, 2001; Kurzweil, 2008). It certainly illustrates the need for women suffering from PPD to access information and support from their peers.

MotherWoman, Inc. is a non-profit organization headquartered in Amherst, Massachusetts. Its philosophy includes the statements, “When mothers are valued and supported, we are more successful in all areas of our lives, benefiting our children, families and communities,” and “...policies that support families benefit everyone.” (<http://www.motherwoman.org/mission/>). With that guiding philosophy, MotherWoman, Inc. claims to offer the only free weekly support groups in Connecticut, Vermont and western Massachusetts for women experiencing PPD. Additionally, the organization conducts free drop-in groups for all mothers to find support for the challenges of motherhood. (http://www.motherwoman.org/?page_id=2). Their innovative group model to support mothers experiencing symptoms associated with PPD is the focus of this research.

The guiding principles of this organization and the groups it conducts include a commitment to feminist psychological theory, an almost unwitting adaptation and application of cognitive behavioral theory as well as dedication to social justice and a reverence for the power inherent in motherhood. With a goal of understanding how these groups work and honoring the voices of those who experience them, I endeavored to illuminate the format of the group model and examine why it is useful. My hope is that by understanding this group format, a contribution is made to the postpartum depression treatment literature. Access to services and treatment is already challenging to mothers experiencing PPD; group treatment is economical and arguably well aligned with feminist collectivist ideology.

MotherWoman's goal is to continue offering these groups, to scientifically assess effectiveness, and to then expand and replicate the model in numerous locations. MotherWoman has some idea of why their groups work; but an objective, academically researched project would both provide clearer evidence to the MotherWoman organization itself, as well as contribute to the body of social work literature an understanding of how feminist psychology can fuse with cognitive-behavioral methods to serve a specific population of suffering women.

CHAPTER II

LITERATURE REVIEW

The body of literature pertaining to postpartum depression is vast. This review will confine itself to a focus on defining postpartum depression, including prevalence and risk factors cross-culturally; treatments for postpartum symptoms including how groups have been used; and the concepts of feminist and cognitive behavioral approaches to treatment that are most relevant to this study. The goal of this review is to bring into focus the value of further study of group treatment for postpartum depression sufferers.

Postpartum Depression: A brief history and definition

Hippocrates recognized the postpartum time as particularly vulnerable for women as long ago as 300-400 B.C. (Dix, 1985; Sichel & Driscoll, 1999). In the nineteenth century, French physician L.V. Marcé began to describe PPD as a problem in the connection between the brain and “organs of generation” which, according to James Hamilton, MD, foretold what would become understood to science as the discovery of the endocrine system (Dix, 1985). During the early 1900s, a shift occurred in thinking about PPD not as uniquely caused following childbirth, but as an indication that a woman was suffering psychiatric symptoms labeled as schizophrenia, manic-depressive insanity, or other psychoses; labels that then became a part of her permanent identity. When psychiatry attempted to classify illnesses according to common symptoms, the word ‘postpartum’ was stricken from the diagnostic nomenclature thus extracting the syndrome

from its connection to childbearing. It wasn't until the 1970s when psychiatrists in Britain began once again to notice, through observation of institutionalized new mothers, that there was uniqueness to this illness that warranted further investigation. This new enthusiasm generated a renaissance of research on the topic of postpartum psychiatric illness (Dix, 1985.)

Currently, postpartum depression is categorized in the DSM-IV by a postpartum onset specifier to Major Depressive Episode as well as other mood disorders, including Bipolar II Disorder and Brief Psychotic Disorder, when the symptoms begin within four weeks of the delivery of a child (American Psychiatric Association, 1994). The range of symptoms experienced in PPD includes feeling dull and joyless, not sleeping for two or three days, losing weight, difficulty bonding with baby, feelings of worthlessness and guilt, thoughts of hurting or killing self or baby, active substance abuse, difficulty making decisions, excessive irritability with baby or partner, withdrawal from family and friends (APA, 1994; Dix, 1985; Kendall-Tackett, 2005; Seyfried & Marcus, 2003). The DSM V is scheduled for publication in May of 2013 and will increase the timing of the onset specifier from four weeks after delivery, to as much as six months after delivery for depressive episodes. The criteria for onset of manic or mixed episodes will either remain at up to four weeks post delivery, or will extend along with the onset of depressive episodes to two months post delivery (Jones, 2010). Nurse practitioner Marla Goldsmith (2007) reports that postpartum depression can manifest up to a year after birth. The implications of this change to the DSM include changes to health care coverage for treatment and money allocations for continued research.

Prevalence and Risk Factors

The reported incidence of PPD ranges from 4-33% of new mothers (Abrams & Curran, 2007; Goldsmith, 2007; Kendall-Tackett, 2005; Seyfried & Marcus, 2003). The great variation in prevalence numbers has partly to do with how the syndrome is defined, what criteria are used. When symptoms of depression are included, rather than solely a formalized diagnosis, there is an increase in rates of prevalence (Kendall-Tackett, 2007). The literature is rife with discussion on the distinction between “the baby blues” and postpartum depression with the less severe incidence of “blues” reaching to 75% of new mothers (Seyfried & Marcus, 2003).

Several researchers have uncovered a common myth that PPD affects mostly white, middle-class American women (Abrams & Curran, 2007; Kendall-Tackett, 2005; Yonkers, et al., 2001). The perpetuation of this myth in the United States can be attributed in part to media coverage of the illness which tends toward sensationalizing either due to the extreme circumstances of the story, or the celebrity of the PPD sufferer. An analysis of magazine coverage from 1980-98 showed that depiction of this affliction profoundly lacks representation of women of diverse racial, ethnic and socioeconomic backgrounds and non-heterosexual women (Martinez, Johnston-Robledo, Ulsh, & Chrisler, 2000). To the contrary, postpartum distress affects women across lines of race, ethnicity, socioeconomic status, sexual orientation and culture (Abrams & Curran, 2007; Crockett, 2008; Wei, Greaver, Marson, Herndon & Rogers, 2008; Yonkers, et al., 2001).

While it potentially affects all mothers, it is also important not to lump all statistics about postpartum depression together across all lines of difference. For instance, within the United States, one study of Native Americans, Whites, African Americans and

Hispanics showed that Hispanic women had remarkably lower rates of depression than all other groups in the sample (Wei, et al., 2008). In a rural community setting another study of minority groups also showed Hispanic women demonstrating fewer symptoms of depression than others (Baker & Oswalt, 2008). Several interesting study results corroborate the international and cross-cultural prevalence of PPD, while also highlighting differences. For example, Kendall-Tackett (2005) reports on studies of depression in mothers from Costa Rica, Chile, Turkey, India, Europe, Australia, Nepal, as well as Hmong and Vietnamese immigrants in the United States with all studies yielding prevalence of PPD symptoms comparable to the range reported in the U.S. Economic deprivation was a common contributing factor, with an interesting exception in Nepal, one of the poorest countries in the world, showing a low (12%) rate of PPD prevalence.

Advocates of preventive care are working to raise awareness of risk factors and promote universal screening of new mothers. Risks factors have been identified in the physiological, psychological, societal, and relational realms (Epperson, 1999; Miller, L. J., 1999). Screening for these factors helps identify who is most at risk for developing PPD and allows for more timely treatment interventions. Research shows, unfortunately, that without universal screening, many risk factors are going unnoticed and women suffering symptoms of PPD do not get treatment fast enough to ensure better outcomes (Abrams & Curran, 2007; Goldsmith, 2007; Seyfried & Marcus, 2003).

Fatigue, sleep deprivation, hypothyroidism, pain, and extreme hormonal changes are all physiological influences that can contribute to postpartum depression (Dix, 1985; Kendall-Tackett, 2005; Miller, L.J., 1999). Psychologically, women with previous episodes of depression, a history of trauma or abuse, loss, family history of psychiatric

disorder, substance abuse, and stressful pregnancy or birth are at greater risk for symptoms of PPD. (Kendall-Tackett, 2005; Spinelli, 1999). In 1977, a study on infant temperament identified a “difficult temperament” in babies who had strong emotional reactivity and cried for long periods of time (Chess & Thomas, 1977). A subsequent study made the connection between the difficult temperament and more prevalent depression in their mothers (Bond, Prager, Tiggemann & Tao, 2001). Chronic health issues in children, including premature birth, have also been shown to effect maternal depression (Kendall-Tackett, 2005).

Studies of social risk factors show that economic deprivation, poor social support, poor partner relationship, immigrant status and infants with serious health problems are commonly noted cross-culturally (Abrams & Curran, 2007; Kendall-Tackett, 2005; Tannous, Gigante, Fuchs, & Busnello, 2008). Mothers in one study conducted in India suffered PPD at rates similar to Western cultures; and while contributing factors were also similar they also uniquely showed increased depression upon the birth of a female infant (Patel, Rodrigues, & DeSouza, 2002). In a sample of Hmong and Vietnamese refugees, an increase in severity of depression was noted in less acculturated immigrants and also showed alarmingly high rates of suicidality (Kendall-Tackett, 2005). A study found that while postpartum depressive symptoms were found in all of 11 different countries, not all cultures believed in the effectiveness of intervention to treat these symptoms (Oates, et al., 2004). Data regarding treatment and risk factors across cultures cautions that treatment options cannot be generalized and require requisite sensitivity.

Within the United States, social risk factors include societal pressures to achieve and maintain a feeling of maternal bliss, lack of community or familial support, and

economic stress (Dix, 1985; Wile & Arechiga, 1999). Sharon Lerner (2010) is a journalist whose recent book, *The War on Moms*, argues that the U.S. is unfriendly to mothers on numerous accounts: maternity leave, quality childcare, equitable pay, healthcare coverage. She highlights, via interviews with mothers, the stress that women feel when faced with the challenges of balancing careers and/or employment vs. spending quality time with their families. By comparing U.S. social policies with those of other industrialized countries, she makes the case that when women and mothers are supported by the social structure, both fertility and productivity rise, decreasing depression and stress (Lerner, 2010).

Treating Postpartum Depression

Treatment of PPD symptoms has varied over the course of time and with increased scientific understanding of the physiologic implications of birthing. The literature on treatment of PPD shows variation in effectiveness and availability to women who need it. They include pharmacological and hormonal interventions, physical exercise, home-based interventions, individual and family therapy, and group models (Calvert, 2009; Daley, Jolly, & MacArthur, 2009; Leis, Mendelson, Tandon, & Perry, 2009; Payne, 2007; Tamaki, 2008).

In the early 1900s, when postpartum depression was believed to have uncovered an existing mental illness rather than being related to childbirth itself, women were treated by institutionalization (Dix, 1985). It was actually through observations made in such institutions in England and Japan that doctors began to reconnect the dots between the symptoms they were seeing and the fact of recent childbirth for these women. Ian Brockington, a doctor in England, called an international scientific conference to discuss

PPD and the emerging understanding of the endocrine system. Following this conference, Dix wrote a book, *The New Mother Syndrome*, that began outlining possible treatments and preventive measures for new and expecting mothers. Dix (1985) called for attention to diet, exercise, nutrition and avoiding isolation to combat depression.

The use of selective serotonin reuptake inhibitors (SSRI's) and benzodiazepines has been shown to be effective and common treatments in the U.S. Some women are reluctant to use medications to treat PPD due to risk factors for self and nursing baby (Drennan, 2009), making it desirable to identify alternative methods of treatment. Additionally, while medications can be effective treatment, they do not treat the isolation that often exacerbates symptoms.

Community-based interventions such as midwife-managed care, home visits, or follow-up outreach calls have been shown useful in promoting treatment compliance, improved mother-infant interactions, and mental health improvements in several cross-cultural studies (Kendall-Tackett, 2005). In her meta-analysis of these and other studies, Kendall-Tackett concludes that community based interventions are useful in helping new mothers transition into new motherhood, but are not able to treat depression effectively unless accompanied by targeted individual treatment. Education of and outreach to new mothers and the general population is critical in bridging the gap between mothers in need and treatment; but does not in and of itself constitute treatment.

Beginning in the mid-1980s, time-limited treatments based in interpersonal psychotherapy (IPT) were used, studied and showed good results (Stuart, 1999; O'Hara, Stuart, Gorman, & Wentzel, 2000). This intervention is well documented as an effective response when social disruptions in one's life contribute to depressive symptoms. Based

on attachment theory and Harry Stack Sullivan's interpersonal theory, the philosophy acknowledges the impact of interpersonal relationships (with a partner, for instance) and the new role of motherhood as factors stimulating difficulty. (Stuart, 1999) Cognitive Behavioral Therapy, another well-documented individual psychotherapeutic intervention, shows effective results in treating depression (Wright, Basco, & Thase, 2006). Based on the premise that distorted thinking (cognition) is the root cause of depression, the therapy works to change a person's thinking to be more in alignment with the reality of their situation and to change negative beliefs about oneself. A study of 87 postpartum women conducted in England showed CBT intervention to be as effective as medication in treating symptoms of depression (Appleby, et al., 1997). Another Canadian study corroborates that CBT is at least as effective as paroxetine (an SSRI) in effectively treating PPD (Misri, Reebye, Corral, & Mills, 2004). The effect of cognitive distortions on new mothers will be discussed later in this paper.

Because isolation and lack of social support are referenced as barriers to lifting PPD (Kurzweil, 2008), group models are a natural treatment response. Research on PPD treatment groups does not provide a broad-ranging assessment of differing models; however, researchers have examined a few specific models. Kurzweil conducted research on a group based in relational-developmental theory. She studied a support group that used a modification of psychotherapeutic intervention wherein the role of the therapist facilitator played an integral role in creating a holding environment, deemed an important component of the treatment. The design included pre- and post-test questionnaires of 49 women, with results suggesting positive outcomes. Limitations in this study have implications for further research. The sample was comprised of "middle class, educated,

and Caucasian” women (Kurzweil, 2008), thus decreasing the generalizability of its efficacy to women of differing racial identities and socio-economic classes. One of the measures was a tool developed by the author of the study and was not tested for validity.

Another study conducted in New Zealand used standard measures (Edinburgh Postnatal Depression Scale, Beck Anxiety Inventory, and the Maternal Attitudes Questionnaire) in a pre- and post-test design to test a CBT and psycho-education group model (Griffiths & Barker-Collo, 2008). The results showed a decrease in symptoms of anxiety and depression as well as improved attitudes toward mothering. Another aspect of this research was that 40 of 45 women were also taking psychotropic medications; the data was examined with no significant influence of medications found (Griffiths & Barker-Collo, 2008).

Klier, Muzik, Rosenblum, & Lenz (2001) assessed a brief group treatment model based on interpersonal psychotherapy originally designed for treatment of bulimia and conducted in Austria. This modality seemed to address individual issues and needs within a group setting, rather than focusing on group support. Findings were positive; subjects who completed the study showed a decrease in their depressive symptoms. In this small pilot study, tools were used to simultaneously measure changes in marital relationship and interpersonal problems as well as depressive symptoms. Only the findings for depressive symptoms were significant.

These three studies focused on groups share a common research limitation - the lack of a control group. In these cases, it would be contrary to social work ethics to withhold treatment for purposes of research. This posed a constriction to research design for this thesis project as well.

Approaches to treating PPD are varied and the literature is more extensive than what has been reviewed here. Accessing care, however, seems to be problematic, even for those seeking it. Racial minorities in the United States are less likely to access a variety of care options; and are most likely treated with individual counseling or hospital inpatient treatment (Zittel-Palmaro, Rockmaker, Schwabel, Weinstein, and Thompson, 2008). Abrams and Curran (2007) pose the challenge for social workers to find treatment modalities that are easily available to low-income and ethnic minority women. One goal of this research is to add study in the area of group treatment models, which have the advantage of reaching greater numbers of mothers, and are economical to administer.

A Feminist Approach

When Jean Baker Miller, M.D. and Irene Pierce Stiver, Ph.D. endeavored in the 1970s to better understand psychodynamics as pertaining specifically to female experience, they uncovered a bias in the theory prevalent at their time toward privileging independence and individualism over interdependence and relatedness. This led to an ongoing study group dedicated to the cause, which yielded a breakthrough contribution to the field of psychology by redefining treatment for women suffering from depression and other stressors. One aspect of their new approach included valuing the connections women need to feel well (Miller & Stiver, 1998). By privileging relatedness over individualism, they began to understand women's groups as therapeutically beneficial and healing.

Based in the concepts of cultural relational theory, Schiller created a model for women's groups that emphasizes that connections within a group are an important influence (Cooper & Lesser, 2008). Applying a stage approach to group development,

Schiller's model differs from traditional models in that the second stage attends to the creation of relationships rather than one of competing for power and control between the group members. In describing the second stage of group progress, she sees that women begin to come together, creating bonds of affiliation which strengthen their trust of other group members; which in turn forms a foundation of safety upon which to explore future conflicts (Cooper & Lesser, 2008). This shift in orientation champions the feminist notion that quality of interaction and connectedness correlate positively to adult health rather than representing an unhealthy dependency. It is important to honor this shift in thinking because it is a point of departure from a norm still very much alive in psychological treatment. A refrain from women suffering with PPD is that they should be able to conquer the symptoms on their own.

Dix (1985) does a thorough job of presenting the difficult history PPD symptoms have endured in terms of recognition for study and research as well as providing women and feminism with another example of how patriarchy and the medical establishment wield power over women's health and wellbeing. Dix offers "A Game Plan for Survival" as one of her chapters, outlining the importance of "Time Out from Motherhood," to alleviate the real stress that occurs and to avoid isolation. Though her writing is addressed mostly to middle class, heterosexual women of the 80's who were experiencing in the political dilemma of choosing between a career and motherhood, the issues are no less relevant and applicable today. Speaking to why support groups are important treatment for new mothers suffering with symptoms of PPD, Dix (1985) recognized that "isolation encourages depression to take root" (p. 194).

In *Feminist Theories and Feminist Psychotherapies*, Carolyn Enns, Ph.D. (1997) discusses the variations in feminist theories, urging us to guard against tendencies to characterize all feminist theory as monolithic. She defines and contrasts liberal, radical and socialist feminism. One universal principle, however, that is particular to the contributions of feminism, is the idea that women's symptoms are created in a context of social oppression and can be considered coping mechanisms rather than indications of pathology. Enns (1997) implored counselors to "critique a society that does not value traditional feminine behaviors as much as traditional masculine behaviors" (p. 12). Dix (1985) also states the importance of recognizing prevailing attitudes and changing them. By acknowledging the faulty thinking or attitudes served up by the sociopolitical milieu, mothers are implored to pay attention instead to the reality of their lived experiences. In doing so, common experiences are noted and women begin to feel less alone, or crazy, or at fault for the struggles and pain they experience (Enns, 1997).

A feminist approach fosters egalitarian relationships between the clinicians and clients (Enns, 1997). This idea embraces client strengths and the belief that clients know themselves best. The clinician brings her/his knowledge to the relationship to empower the client toward her own healing. In the relational-cultural therapy model developed out of the work of Miller & Stiver (1998), desire for connection is healthy and growth occurs when clients feel a mutual sense of importance with their therapist, or others in a group.

Breaking silence is another feminist value that is relevant when talking about PPD. Many, perhaps all, stories of women suffering with postpartum depression include phrases like *the veil of silence*, and *keeping up appearances*, (Mauthner, 2002) or feeling *ashamed, guilty, downright afraid of being classified as insane* (Dix, 1985). A shroud of

silence increases shame and prevents the healing that human bonds promote. When people/women feel able to bring even their least desirable traits into relationship with others, they feel more accepted and are more able to heal (Miller & Stiver, 1998).

These foundations of feminist theory are intended to create a foundation upon which to stand and view MotherWoman's model of group treatment. These principles are in direct alignment with the founder's intention of creating groups that empower, connect and respect the experience of women as mothers. It is important to honor the depth of feminist action that came before it.

Concepts of Cognitive-Behavioral Therapy

As stated previously, feminism helps us understand that women operate in a social context which can present obstacles and oppressive conditions that require coping mechanisms, some of which may not serve their highest good. Cognitive-Behavioral Therapy, a highly studied and effective form of treatment, purports at its core a connection between thoughts (cognitions), behaviors and emotions, such that emotional states can be altered at the cognitive or behavioral axes to promote change (Wright, et al., 2006). And a research study of 87 mothers treated for postpartum depression found that "CBT was as effective as medication" (Appleby, et al., 1997). One component of CBT involves examination of faulty thinking. These *cognitive errors* have been identified in people experiencing depression and categorized into several types (Wright, et. al., 2006). Though some of these types infer that individuals make cognitive errors, women suffering with postpartum depression are influenced by thinking that is presented by their social context. For example, one of the errors, *arbitrary inference*, refers to making "a conclusion "in the face of contradictory evidence" (Wright, et al., 2006, p.11). Our

cultural messages to women are that motherhood should be experienced as blissful, natural and easy. When exhaustion, isolation and fear set in, a cognitive dissonance is experienced that contributes to lowered self-esteem, hopelessness, self-blame - the symptoms of depression.

Another insidious cultural message is that mothers universally and unconditionally want to care for their babies all the time. This message sets women up for feeling inadequate since motherhood can also be depleting and frustrating. Since she is no longer in alignment with the supposed “norm”, an exhausted or fearful mother might be quick to blame her self, contributing to depression. In CBT treatment, one of the techniques employed is to examine this thinking. By identifying negative thoughts that contribute to depression, often a patient sees the underlying error of that thinking (Wright, et al., 2006). For instance, when the notion of universally blissful motherhood is examined, its faultiness is exposed. This might provide comfort to a mother and propel her to seek treatment. It also, according to CBT principles, helps the mother externalize her problematic symptoms as something she is experiencing, rather than as an unalterable trait that lies within. Once identified, the work of changing, or restructuring, these distorted thoughts begins.

Since the 1980s when Dix (1985) wrote that the myth of motherhood does not match, necessarily, women’s lived experience, this dissonance has been at the root of understanding the affliction. Denying one’s true experience has a monumental impact on self-esteem. The internalized pressure to perform to meet the standards of society and the reified myths are a central cause of distress in new mothers who experience stress, sadness, exhaustion and regret. Cognitive restructuring provides a technique wherein

mothers can more accurately align with reality. Within a group format, participants create a new set of norms and ideologies that better serve their specific needs and concerns (Kurtz, 1997). From this more accurate starting place, the work of creating mutually respectful relationships and gaining honest support can occur. Behaviorally, CBT encourages the individual to take part in enjoyable activities, or self care, to combat depression and anxiety (Wright, et al., 2006). Behavioral changes can have a positive impact on outlook or cognition and include planning pleasant events and relaxation training. The aforementioned pressure to put babies' needs first creates an untenable situation for many mothers who simply don't have the time, resources and support to provide 24-hours-a-day care to an infant. Learning to balance care of self with taking care of others not only replenishes the mother, but also restructures the thinking that self-sacrifice is somehow of higher value than strengthening the self.

One chief principle of CBT is that some of our automatic thoughts are driven by the underlying schemas, or deeply held beliefs about ourselves. The *stress-diathesis hypothesis* of CBT harkens back to what was thought of during the early twentieth century as postpartum symptoms revealing an underlying existing psychosis. This hypothesis says that a stressful life event (such as birthing) might activate a maladaptive underlying schema that was previously not operating (Wright et. al., 2006). This philosophy might help shed light on why some women are not noticeably at risk for PPD, yet experience it. Or, perhaps it creates a bridge between the impact of early life events and postpartum distress, useful in screening as well as in guiding individualized treatment.

Facilitation

Facilitation of groups can take on different forms and characteristics. Brandler and Roman (1999) distinguish three models: reciprocal/contractual, remedial/rehabilitative, and psychosocial. In describing the benefits and applications of these styles, they also discuss the leadership role that correlates with each. A contractual model engenders a democratic atmosphere, leading participants toward empowerment and self-discovery. The facilitator is non-directive, open to change within the group process and trusts the group members to unearth their own inner wisdom. A remedial model requires facilitation that assumes the therapist has expert knowledge to impart to the client(s) and therefore dictates a more directive style. The psychosocial model works by using long-term relationships within the group to foster insight based on the themes that emerge out of those relationships. Here, the facilitator assumes an expert and authoritative role to establish and maintain appropriate boundaries and norms in the group. This leadership requires clear separation between leader and client group (Brandler and Roman, 1999).

A study of a training model for working with families (Webster-Stratton, 1998) found that one component of their model was a collaborative training model. While this study in particular was to assess a different issue – that of training parents whose children are exhibiting problems in school – the discussion and finding of how participants related to the method, is relevant to this paper. Webster-Stratton (1998) describes the facilitation:

Does the collaborative trainer have to renounce this expertise? Hardly. The collaborative training model acknowledges that expertise is not the sole property of therapist or trainer: The parents function as experts concerning their child, their particular family, and their community, ... The collaborative trainer labors with parents by actively soliciting their ideas and feelings, understanding their cultural context, and involving them in the therapeutic process by inviting them to share (p. 189).

This study further showed that when parents sought one another for help and support outside of the group, their outcomes were better. This style of leadership is in keeping with the feminist principles discussed earlier, namely privileging clients' understanding of themselves, and creating egalitarian relationships.

Summary of Literature Review

This literature review is intended to provide the reader with an understanding of the compelling need for effective, accessible treatment for symptoms of postpartum depression. As a uniquely feminine affliction, the case can be made for modeling treatment within the theoretical framework of feminist psychology and its particular focus on considering the context of oppression and devaluation of women. This context creates a set of circumstances in which women in general, and mothers in particular, have to combat a prevailing belief that they are inferior, by developing coping strategies such as independence, hyper-functioning, and suppression of emotion. During the vulnerable postpartum time, these strategies operate against mothers who need nurturing, connection and support. Group treatment is cost effective, able to reach a large segment of the target population, and it inherently provides connection and relationship to other women.

Groups are complex treatment modalities with numerous aspects to consider, some of which are addressed in this review of literature. The task of MotherWoman's PPD support group is to help alleviate the suffering associated with postpartum distress. Through this review I intend to have laid groundwork for examining an innovative group model and create a bridge between what makes these groups effective and the theories they are based upon.

CHAPTER III

METHODOLOGY

This research sought to understand the specific nature of MotherWoman's Postpartum Depression Support Group and how it benefits the participants. This researcher attended and observed three actual groups, met with the Director of MotherWoman, Inc. and facilitators of the support groups, and conducted a focus group of women who had attended six or more of these support groups. Data collected via the focus group was examined for predominant themes. Those themes were examined to assess how well they reflect the intention of MotherWoman to provide a supportive environment in which mothers can be honest about their postpartum experience and find relief as well as empowerment.

MotherWoman, Inc. is an organization that conducts several groups for mothers, including ongoing, weekly free support groups for mothers experiencing symptoms of postpartum distress. These groups are offered in four locations in Western Massachusetts. The design of this particular group model was originated and developed by the organization's co-founder, Annette Cycon, LICSW. It contains several distinct components and allows for flexibility during the actual facilitation. The distinct components (principles, guidelines, tune-in, check-in, discussion, check-out) became the framework upon which the focus group was conducted. If MotherWoman's support group is the only one in the nearest three states offered freely to women suffering with

symptoms of postpartum depression (as is their claim), it would be useful to understand what they do and why they are useful. I endeavored to bring this to light via the voices of the participants themselves.

A focus group research method was chosen in part because it paralleled the participants' experience of attending a group, while offering an opportunity for data to be collected in a dynamic, conversational research style. Rubin and Babbie (2007) believe that focus groups are good tools for determining the usefulness of a program. It would have been ideal to convene two or more focus groups to provide better generalizability; however, time constraints and challenging scheduling situations have allowed for only one. The fear is that one group could be considered atypical and not representative of the larger sample (Rubin & Babbie, 2007). In this instance, it is reasonable to consider the group that met to be representative of participants because they seemed similar to the groups I had previously observed and expressed views similar to those I had previously encountered. One of the goals of this support group, as stated by MotherWoman's mission, is "to empower women to create personal and social change through telling the truth of their experiences as mothers" (MotherWoman, 2009). By soliciting their testimony, the research process itself could further the organization's goal of empowerment of women's voices.

Sample

Six women participated in the focus group. Purposive sampling was used since the participants had to meet criteria of having attended at least six sessions of the group that met regularly in Northampton, MA. That eligible population was identified through attendance information available in the organization's database. Eligible subjects were

recruited via an email invitation (see Appendix C) that further narrowed selection criteria to include women over the age of 18, English speakers, reporting postpartum distress within the first 12 months postpartum, and women who were not facilitators of the groups. This initial selection process yielded 15 possible subjects. The original plan was to conduct the group in an afternoon, directly following the regularly scheduled support group. However, when it became clear that this time was not convenient for enough women, one participant volunteered to organize a meeting at her home. This also proved difficult to organize due to schedules and timing. With permission to use the offices of MotherWoman, Inc. in Amherst, MA, a group successfully convened on an evening, independent of regularly scheduled groups. A local restaurant donated food. Nine women responded to the final invitation, three declined, and six confirmed their plans to attend. All six attended.

All subjects met selection criterion, having attended at least six groups. Five had met one another in a group at some point and so there were varying degrees of familiarity among the participants. Demographic information regarding race, socioeconomic status, sexual orientation, and age was not collected in order to protect the women's identities, given the small size of this group. There was one woman of color and discussion revealed that there was some variation of socioeconomic background represented.

Ethics and Safeguards

A risk of this research is that while the researcher protects confidentiality, the participants' adherence to confidentiality agreements cannot be guaranteed. The researcher will not release the names and other identifying information to anyone; however, these participants are members of a rather small community and are not bound

by the same ethical standards of the researcher. Informed consent forms (Appendix D) and opportunities to ask questions were presented prior to taping the focus group session.

Another risk of participation was that subjects might feel distress about their own mood or symptoms, or about the support group itself. If a subject was displeased with her experience of the support group, this could evoke further distress in others as well.

Resources for support, counseling and crisis response were made available to participants prior to, during and following the focus group session.

A digital audiotape of the focus group was created and stored in a locked box by the researcher and access only granted to the researcher and the research advisor. This data has been transcribed without identifying information. Data will be reported as aggregate findings, with individual quotations used, anonymously, for illustration.

Data Collection

The focus group convened in the evening, in a private, pleasant office space made available for this specific event. The only people present in the building were the researcher and subjects. This researcher used a semi-structured format to conduct the focus group, asking open-ended questions to inspire conversation. After consent forms were signed, questions answered, and the audiotape turned on, participants were asked to comment on their experience of the first of the group components, the principles. These were available (see Appendix E) in printed form for reference. Participants were asked to reflect on which of these principles was most relevant to them and why. Each of the remaining components was presented in turn: guidelines, tune-in, check-in, discussion, check-out/closing; and open-ended questions were asked (i.e. what effect does the tune-in portion have on you? What is the benefit of checking-in?)

Focus groups have the advantage of possibly stimulating new ideas because of the interaction of the participants (Rubin & Babbie, 2007). Different from completing a solitary questionnaire, or being interviewed privately, individuals in a focus group are encouraged to add and build upon one another's comments. This occurred. During the conversation, the researcher occasionally summarized comments and encouraged expression of dissenting views and invited participation of all present.

The 70-minute conversation was audiotaped. Having been asked to give one-hour of time, the participants were asked about their interest in continuing the conversation past that hour. All agreed. The researcher transcribed the audiotape.

Data Analysis

Prior to conducting the focus group, I attended three sessions of the postpartum support group over the course of a year's time. In doing so, I was able to note the specific components, be a participant-observer in the process, witness the ambiance, and observe the facilitation. This provided me with some insider knowledge from which to consider the results.

The transcripts were coded to identify major themes. These themes were then examined for their relationship to cognitive-behavioral methods and feminist theory. A discussion of this relationship is found in the next chapter.

CHAPTER IV

FINDINGS

To answer the question, “How does MotherWoman’s PPD Support Group promote healing in new mothers?” an analysis of the group’s structure will be presented, followed by presentation of the major themes identified in the collected data. These themes will be reported as expressed by the focus group participants, and then examined for their relationship to the literature on feminist theory and cognitive-behavioral methods.

The Group Model

Following my observations of three group meetings, and in conjunction with the program director, five distinct parts of the group structure were identified: reading of the guidelines, a tune-in exercise, check-in, discussion, check-out/closing. Underlying the group model is a set of principles that provide the foundation of the group. During the focus group, the principles and each of the structural parts was presented to the participants, and their comments solicited. Specifically, they were asked to describe the perceived function of this part and to comment on what they did or did not like about it. The principles will be presented first, followed by a description of the structure itself.

Principles

For me, definitely, ... the fact that it was a safe environment was definitely a big one. That I didn't have to go in there afraid of what I was going to say and what the consequences of that might be.

– mother/research participant

As this participant indicated, the *principles* of MotherWoman's groups are the underlying beliefs that guide the tenor of the meetings. (See Appendix E for full statement of MotherWoman Group Principles.) They include an intention to provide space for mothers of any race, class, age, sexual orientation and lifestyle to express themselves honestly and without fear of judgment. Additionally, there is an assertion that it is "a revolutionary act" to break silence about the isolation and oppression of women experiencing PPD. MotherWoman acknowledges the paradox of mothering, choosing not to deny or "sugarcoat" the challenges. There is a commitment to empowerment which is expressed in the belief that each woman has "the wisdom within to navigate her life," when she is supported and nourished.

These *principles* work to drive the group process. The focus group was asked to look at these written *principles* and to comment on which of these had an impact on them and why. Here is what three different participants had to say:

I feel safe going in there, knowing that everything I say is going to be validated. Nothing will be trivialized ... you're not going to be made to think that something you feel is a big deal, isn't a big deal.

Another big one for me was just the fact that ... regardless of race, class, age, sexual orientation, lifestyle or parenting choice, you could choose to do anything you wanted to do with your child, more or less, and people weren't judging you on that. And it didn't matter if you lived in ... a big huge house, or you know if you lived in ... a tiny little apartment.

I think too the paradox of the stress, pain and joy all together ... that it's supposed to be joyful, and then sometimes it really isn't, like there's no joy whatsoever.

Participants confirmed that these *principles* are implicit and can be detected throughout the two-hour long groups. What actually occurs during the groups follows a format that

has some flexibility but, as is stated in the principles, also has “the intention of creating ... consistency.” The support groups start with a reading of the guidelines.

Guidelines

One thing about the confidentiality that’s so important, it allows you to say things you would never ever say anywhere else, like "I hate being a parent" "this was the worst decision I ever made in my life." ... But you know they are only going to stay in that room, that no one's going to judge you. ... Big taboos can be expressed there.

– mother/research participant

The explicit *guidelines* are both the perceived and stated bedrock of the program. A focus group participant said that these are what “makes the group.” (See Appendix F for full statement of Guidelines.) They are briefly: honoring confidentiality, not giving advice or interrupting, showing respect and non-judgment, not considering this a therapy group, and promoting self-care. This group member described her appreciation of the atmosphere of acceptance:

I think that’s why the non-judgment is huge because – I haven’t encountered too much of the *mommy wars* kind of thing, but it never comes into that group at all, right? (Mommy Wars as in ‘I do it this way, so I’m better, and therefore my kid’s better.’ Competitive. There was this book called Mother Wars and that gets referred to a lot. One of the big mommy wars is the stay at home vs. the working mom and just how that plays out.)

Addressing the *guideline* of no advice giving and not interrupting, one woman stated that this is what makes these groups “so successful,” in contrast to her experience outside of the group:

From the minute you tell people you’re pregnant, advice is the first thing they hand out ... and it’s jammed down your throat.

This is not a therapy group, but a support group. As this participant described it, there’s no pressure to perform:

It's not therapy ... but you get to go, you get that release, and ... you don't necessarily have to make any progress. You're not going to go back the next week and have them be like, "soooo, how are we doing this week?"

Tune-in

You get into the zone of MotherWoman. It's like meditating. It's like the meditating at the end of yoga class, except it's at the beginning. Everyone's quiet all of the sudden.

– mother/research participant

That is how one participant described her experience of the *tune-in* activity, which includes simple relaxation techniques and is designed to delineate the beginning of the group, help group members slow down and reflect, and to begin the practice of self-care. This focus group expressed difficulty with the process, one participant said, "I don't do it well." Another said, "I don't like any form of meditation, and that qualifies." One woman shared her difficulty this way:

When I can actually participate, and actually get my brain to slowly do it, it's a really beautiful, glorious thing, but I need like 40 minutes of preparation to get those ten seconds of stillness.

Another participant who felt positively about the exercise said:

I would actually try to do it at home. I would. Especially in the Fall, I was in a pretty bad state. I would actually do it at home. I don't think I would have if I hadn't done it in group.

Despite wrestling with this activity, none of the participants in the study thought it should be excluded from the format, stating that it provides a valuable reminder. This mother went on to describe that:

The purpose ... is to really notice your body and to notice your self, you your self as you, and not you your self as mom, or as wife, or as partner, or as girlfriend. Just you, it sets a really good state for the check in, where it's just your time to speak about you.

Check-in

It's the only time in the entire week that's mine, at all. That time is so sacred. That non-interrupting piece is great because that's just there, mine, nobody's going to say anything. I can say the most crazy stuff ... So it's mine, it's validated, it's quiet. It's my voice I hear back. It's really hard as a mother of two to hear your voice.

– mother/research participant

Check-in is “the heart of MotherWoman” PPD support group, as one group member put it. It provides an opportunity for each woman, in turn, to speak about her self. The parameters of topic are broad and at the discretion of the speaker. In describing this part of the groups, participants talked about the value of hearing one's own voice and the benefits of listening to others. One woman described it like this:

... the other piece, is hearing other people's voices. You have to listen, you have to be an active listener. It's a very nice lesson for me to listen to the other voices. And it's so important to me to be witness to those voices.

Several participants also described the ways in which they have been changed by this process, and how it has promoted positive change in their personal lives. These comments by one participant expresses one example of a change she has experienced as a result of participating in *check-in*:

... when you listen to the other people's stories, that's when I've found that I've done the most growth as a person. Like the times when someone is telling a difficult birth story, and you can tell that it's breaking their heart to have this birth story, and that they've finally gathered the courage to say that. The empathy and tears you have ... So the empathy that you learn and just the growth, for me that was always the biggest deal.

Discussion

I just feel like I never know what it's going to take out of me and I surprise myself when I go in there.

– mother/research participant

The format for group structure includes a *discussion* following *check-in*. There is no lesson plan and the topic is up to the facilitators. Focus group participants described the *discussion* as occurring organically, “sometimes there’s just a common theme running through the group and they will pick up on that and make it the topic.” By contrast, holidays (such as Mother’s Day) or current news events seem to catalyze a more conscientious effort to present a discussion topic. This fluidity in the structure seemed to appeal to the group members. “I actually like that it’s not a set curriculum,” one woman commented. And according to these subjects, sometimes the *discussion* doesn’t happen at all. If the *check-in* is particularly long, or there is a large group, it is not always included as a separate portion of the group.

Check out/Closing

It does just ... end the group smoothly and offer that sort of closure for that time that may have been very intense. It sort of helps ease you back into reality, or non-reality as the case may be.

– mother/research participant

The *check out/closing* portion of the group serves three main purposes: it offers an opportunity to reflect on the group experience; it directly addresses the concept of self-care; and it creates a border between the event of the group and the participants’ entrance back into life outside of group. There is a closing ritual in which each group participant takes her turn to say what she most appreciated about that day’s group and also what she intends to do during the upcoming week to take care of herself. This mother reflected on the process of stating her intentions to take care of herself and it’s effectiveness:

I found that self-care concept really helpful for me. I would do what I said. And ... I’m still like that now because of this group. I’ve got a thousand things to do, my house is a mess, there’s poop laundry everywhere, but

I'm going to sit and read this magazine. I'm going to do it. I'm gonna drink my coffee ... it's all going to be there in an hour.

The focus group's discussion of *closing* provided some insight into the multilayered benefits they gain from the group. These comments from four different mothers describe some of the benefits discussed:

MotherWoman group was my Tuesday activity. My baby went with me, and there were other babies, so while I got all the other benefits from it, it was also his activity for Tuesday morning. So that was also a big part of it, his being able to socialize as well. Sometimes it was just a place to go, and people to be with.

I always walk out the door, feeling lighter and grateful ... Sometimes it was a struggle to get there, but I always found myself pushing forward. It's almost like I was addicted to how I felt at the end of it ... so much better and happier about the world.

MotherWoman for me, has always been two hours to sit with "J" and not have to address the needs of my older child. Which was so nice because with a second kid, I didn't get to bond. I just didn't feel ... that we had time where it was just us. And when he ... would sleep on my chest for a couple hours, it was the greatest thing ever. I got two hours with him to sleep on my chest and I got to listen. And really, I would be so grateful just to be there.

I'm so thankful that my kid stayed in childcare for an hour and you held him while I went to the bathroom.

Additionally, the *closing* includes a ritual of pulling a card from a velvet bag. The cards, which are inscribed with a word, serve as a prompt for reflection to be shared verbally, or not, as the participant wishes. This mother describes that ritual:

It feels like I'm a little kid getting to pull something out of a little grab bag. And ... when somebody pulls *birth*, or *expecting* ... we all think that's very funny. Some of the groups I've been to you ... give your card to somebody else, and that's my favorite thing to be able to do. Because ... even if it's somebody you don't really know ... you can just show them either that you really connected with their story, or that you really feel for them and you really hope things improve for them, or it's just kind of a non-spoken sharing of emotion or something. I really like that.

This concludes a description of the flow of the group format as described by the participants.

Themes

Validation/Normalizing

Major themes that emerged from analyzing the discussion of the focus group included validation, compassion and importance of self-care. Numerous authors speak about and give accounts of how women are damaged by comparing their lived experience to mythological notions of motherhood (Dix, 1985; Kendall-Tackett, 2005; Mauthner, 2002; Shields, 2005). The pressure of society has, arguably, contributed to a collective cognitive distortion telling women that new motherhood is a blissful time to be cherished and that if one is not experiencing it that way, she is somehow failing in her new role. Brooke Shields (2005) broke silence about her experience in *Down Came the Rain*, a personal memoir about her struggles with PPD. She was assisted by her celebrity in providing widespread validation to many mothers who appreciated reading an honest, personal account of the unique struggles of PPD. When depression compounds the challenges to new motherhood, it can be even more difficult to tell the truth. In her book,

The Darkest Days of My Life, Natasha Mauthner (2002) writes:

In a culture that vilifies and condemns mothers who do not show undying love, affection, devotion, and unswerving positive feelings toward their children, it is easy to understand how postpartum depression groups can provide a safe place in which mothers can talk about “unspeakable” thoughts and feelings (p. 176).

With many opportunities to speak about the joy and bliss of motherhood, and few places to say the “unspeakables,” the mothers who participated in this focus group research

found relief in rounding out the picture of their experience. The following comments are from three different women who address the power of having a place to be honest:

There is a place you can go and just acknowledge that this just sucks – this is the worst thing I've ever done.

It's probably one of the first places I went where I was like, ah, there's other people who think it sucks too. And nobody's gonna say things like, "oh, isn't it so great that you have the year off?"

... a place where there were other people who's experiences were aligned. Cause it's not something you're "allowed" to talk about in just normal play groups, or with your family.

A method used in Cognitive Behavioral Therapy (CBT) is to discover automatic thoughts and examine faulty thinking. In this group, the discovery begins through the act of validation. If the pervasive cultural message about motherhood is that it should be blissful, then a mother who doesn't experience this might develop a faulty thought that she is not a good person, not a good mother. A mother expressed this with a specific example:

...it's common for people to say, "You're supposed to sleep when the baby sleeps." But if you actually do that ... and didn't vacuum, well, you know, you're not as good a mom because you didn't vacuum.

By giving voice to the reality of one's experience, a more accurate picture emerges and is known; and the witnesses benefit as well. Two mothers' comments illustrate how this occurs in the support group:

I could say the things that I was really thinking and feeling without worrying about what was going to happen to me if I said those things.

I had felt like a bad person for a long time and in that space, when somebody said something, I mean, I know that I just sat there and cried while she was speaking because it felt so good that I wasn't the only person on the planet with those deep, dark thoughts.

As Miller and Stiver (1998) discovered, when people are able to bring both their desirable and less desirable traits into human interaction and be accepted, they can more fully heal. These comments by two different mothers describe that experience:

Some of my most unique friendships have come out of the group, ... in a traditional friendship it would take years ... to penetrate those inner layers... But with MotherWoman those inner layers have been penetrated right away and people know my deepest, darkest, baddest days. ... So the level of trust and the level of love for those people is outstanding.

That was the one time during an entire week that I didn't have a facade up, when I was actually being me, ... the way that I felt and saying those things instead of smiling at people and everything's great and I love my baby and it's great. You could really just be who you were at that point in your life. That was really important.

When women gather and tell the truth about their experiences, something shifts. Their experiences are normalized and the result is a decrease in feeling isolated, alone, wrong, or bad. One mother spoke to the power of normalizing:

... hearing what other people have to say helps me figure out what normal actually is. Because the family that I come from, their normal is not actually what is really normal. ... so I don't have a good baseline for what normal is. Being in the group and hearing other people's check-ins ... to hear how they as parents interact with their ... children ... I've learned a lot from that. Because it's like, okay, no one else is actually perfect.

Schiller's relational model of groups posits that when women feel safety within a group, they become able to face challenges more effectively (Schiller, 1997). A mother spoke about her own personal challenges and how the group experience began to change her sense of confidence:

... sometimes I'm intimidated by people. And MotherWoman definitely lessens that, ... it gave me strength. ... It made me look around and say, "oh I am intimidated by someone who is as miserable as I am." It's just power in numbers. Well, I have confidence issues and I think MotherWoman dramatically changes that.

The combination of attention to cognitions, along with the supportive environment of the group can empower an individual to tap into her own wisdom. This statement from one of the mothers describes the process:

Check-in was helpful for me because I really felt like there was a lot of stuff running around in my head and a lot of feelings that were not agreeing with each other. And sometimes to come out and say it, I felt was the next step for me to try to figure out how to deal with it. Instead of internalizing everything, which is what I did.

This illustrates how this group model provides ample space for self-reflection, uses the group for support, and employs CBT methods towards the goal of greater clarity.

Non-judgment Engenders Compassion

A second theme that became illuminated during the focus group discussion was the power and positive repercussions of practicing non-judgment. One of the *guidelines* of the groups is that participants do not give advice to one another. Giving advice can infringe on a listener's ability to discover for herself how she would handle a situation. This leads to disempowerment. A foundation of feminist theory is that each client knows her self and that the clinician's work is to support her own unfolding and self-discovery, rather than providing her with expert knowledge that she lacks (Enns, 1997).

... you know that whatever I say, no one is going to give me advice about how to handle it. That basically is what creates the group for me. That's why I think it's so successful.

I have this friend ... and everything I say about my son she has to jump back with "wait until this happens," or ... when they're crawling it's like, "wait until their walking." It's just that whole jumping in with their own commentary. [In the group] you can say things without worrying that somebody's going to come back with any kind of remark.

Several women pointed to how the behavior supported in the group developed into personal skills that they valued. Learning to be less judgmental of other parents, and people in general. One mother described it:

I have found that hearing other people's stories and struggles has helped me be a much less judgmental person in everyday life. Being able to have empathy for people. ... I see a lot of crazy parenting going on, and my view of those parents has changed. It's done a 180 since having my own child and going to these MotherWoman groups and getting to hear the experiences of other people. It just has totally opened my mind to other ways to do things, and how people cope and survive as a parent.

Another mother described that active listening also engenders empathy between group members:

... when you listen to the other people's stories, that's when I've found that I've done the most growth as a person. Like the times when someone is telling a difficult birth story, and you can tell that it's breaking their heart to have this birth story, and that they've finally gathered the courage to say that. The empathy and tears you have, ... the empathy that you learn and just the growth, for me that was always the biggest deal.

In addition to greater acceptance of others, two participants talked about the healing effect on their own families of origin:

I think that going to MotherWoman has helped me come to better acceptance ... of when my parents were parents. I realize now that they were just trying to do the best that they could do with the resources that they had. As opposed to feeling very negative towards them.

It sort of helped me actually sort out in my head my relationship with my mother.

The effect of listening without interrupting is that the listener's empathy grows and she begins to respond with compassion. Furthermore, the empathic connections created begin to antidote the isolation mothers with postpartum depression report.

Self Care

Caring for oneself can be considered an act of compassion turned inward.

Mothers in this country find themselves in a society that does not support them with structures such as adequate maternity leave and health care (Lerner, 2010). This lack of societal support, added to the stigmatization of being depressed postpartum, is even further compounded by the insult that self-care and nurturing of adults is often viewed in our society as a weakness. MotherWoman, Inc. has the intention to break down this myth and instead states that “mothers cannot give from a depleted source,” acknowledging that the physical, emotional, spiritual and mental needs of mothers must be met in order for them to be effective parents. One mother summarized the contrast between the messages she received in the group vs. the messages received outside of group:

There is this emphasis on self-care. I just felt like in my normal life, no one would remind me that I should take care of myself, not your baby right now. I felt like I was being pampered almost, just from being there.

This mother corroborates the uniqueness of finding this message in the group, yet also describes the critical nature of the concept:

‘Mothers cannot give from a depleted source,’ there are so many lines that I can repeat, because they’ve become part of my mantra, you know, you put the oxygen mask on yourself before you put the oxygen mask on your child. So that idea that you can’t give from a depleted source. Tuesday was like a recharge your batteries kind of day and like I can make it through the week if I made it here.

Part of the myth of motherhood, and arguably women in general, is the notion that taking care of others is the primary job, taking care of oneself is secondary. One participant stated it quite graphically:

I think that the self care piece of it, even though maybe you don't actually do what you say you're going to do, I think it's good because it validates

that it's okay to take care of yourself. It's okay to take, whatever, even if it's a small little thing like take a shower by myself with the bathroom door closed. Something that sounds ridiculous, but it really isn't, it's huge. You know it's okay that you don't take care of your child every single second of every single day, that you let somebody else do it.

The emphasis on self-care is written into the principles and actively nurtured in the closing ritual of each group. It is perhaps most succinctly encapsulated in the statement “It takes a village to support a mother” (A. Cycon, February 15, 2011).

These three major themes coalesced during the discussion. Some additional topics were raised nearing the end of the focus group meeting and will be discussed in the conclusion: facilitation, suggestions for improvements, and speculation about why it took so long for these women to be referred to the support groups.

CHAPTER V

CONCLUSION

This research accomplished three things. It produced a detailed description of the format of the support group, provided an understanding of its value as perceived by the participants, and clarified the theoretical underpinnings that drove the creation and implementation of this group. Focus group discussion helped illustrate how feminist and cognitive behavioral theories are enacted in this specific treatment. It is hoped that this research aids the possibility of replicating and improving this program so that groups can be made more available to women who could benefit from receiving such a service. Though this research did not contrast support group intervention with other forms of treatment, it provides initial compelling data to suggest that group treatment is a particularly valuable intervention for women suffering with PPD.

In addition to the predominant themes already discussed, the style of facilitation is congruent with feminist and cognitive-behavioral theories. Facilitation by trained leaders can be characterized as egalitarian. The leaders' roles are to facilitate the group members' individual empowerment and self-discovery, rather than to be directive or hold an expert stance. The value of this style is confirmed by the reports of mothers in the focus group.

Limitations of this research include a small sample size and lack of control group. This research does not present evidence that this support group alone provides adequate treatment for women suffering with symptoms of PPD. Perhaps a future study could focus on the benefits directly attributed to this group, controlling for adjunct treatment

such as medication or individual therapy and using validated measurement tools to assess symptom relief. Given the representative nature of the sample, however, the data does suggest that this group is successful in providing support, altering cognitions, and preventing isolation.

As a result of feedback from the focus group, this researcher posits that information regarding availability and benefits of support groups should be disseminated to health care providers and to the public. Consistent with the literature, universal PPD screening was not experienced among the study participants. One woman urged better marketing of this group:

I live in this area, I was pregnant, I had prenatal care, I delivered in a hospital and I had a history of depression, so I was forced to see a social worker before I was discharged. And never once did anybody tell me about this group.

And another commented, “I didn’t find out about this group until I had already crashed and burned.” Yet another described her frustration with being offered pharmaceutical treatments or a crisis hotline when what she eventually found beneficial was this support group. As the participants speculated about why they did not hear of this group in a more timely fashion, questions arose as to whether prenatal health care providers were unaware of the group, or if they didn’t trust the efficacy of such a support group.

Finally, participants offered some feedback for improvement to the program itself. The predominant suggestion centered on being offered explicit permission to leave if the group had low attendance (2 or 3 people). One woman’s feedback described the stress of having to engage in “these more philosophical conversations ... I feel like I have to say something profound, it’s too much effort,” when there is a small number of people.

Another suggestion was to add groups for partners of those suffering with PPD, including male or female partners, with one mother stating, “it’s really hard to live with someone who’s depressed and you add this baby onto it. I can’t even imagine how much he struggles ...” The call from research participants was for larger and more groups, expressing the desire to expand the reach of this program.

Positive feedback from the study participants, and compelling literature about the need for increased access to treatment, suggests that MotherWoman offers a valuable opportunity for mothers in western Massachusetts to receive PPD support. This investigation into the program does not offer conclusive evidence regarding its effectiveness in diminishing symptoms of PPD; however, the voices of mothers whose lives were affected by their attendance in the group do speak clearly and loudly about the benefits they experienced. By applying a theoretical understanding to the form and function of the groups, this research offers an example of a fusion of feminist psychology with cognitive behavioral theory in action.

The focus group format of research provided a valuable exploratory report. Not only did it offer an opportunity for women to add their voices to the growing body of research, but it also displayed the benefit of several women coming together to share ideas. The focus group exemplified that the shared values of compassion and acceptance, along with their commonality of experience, allowed participants to freely express their differing opinions and thoughts in one another’s presence. Future study using individual interviews could prove interesting and valuable, but would assess very different aspects of the participants’ experience. A next step to understanding the efficacy of MotherWoman’s program could be to conduct a pre- and post-test evaluation of

symptoms associated with PPD after participants attend a number of sessions. There are several validated testing measures available. A larger number of participants, and ideally representing different group locations, would also provide broader feedback. It would be interesting to learn if participants are simultaneously engaged in individual treatment or are receiving medication to address symptoms as a way of beginning to understand the role of the support group in their healing. Since these groups are ongoing, and the organization is open to its own growth, it is reasonable to suspect that eligible study participants will continue to be available.

Research on women's treatment must continue to privilege their voices and be understood within their cultural context and challenges. While scientific evidence may help determine specific treatment modalities to directly address PPD symptoms, the usefulness of support groups should continue to be assessed from a slightly different perspective, never ignoring the value of women's connections in affecting mental and emotional health.

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APPENDIX A



Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

March 29, 2010

Leslie Lauf

Dear Leslie,

Your amended materials have been reviewed and they are fine. We are happy to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

A handwritten signature in cursive script that reads "Ann Hartman".

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Roger Miller, Research Advisor

APPENDIX B



February 1, 2010

Ann Hartman, Chair of Human Subjects Review Committee
Smith College of Social Work
Smith College
Northampton, MA 01060

Dear Ms. Hartman,

I am writing to confirm that MotherWoman has agreed to allow Social Work Graduate student, Leslie Lauf, to conduct research of our postpartum program, which consists of a support group designed for mothers at risk for or experiencing postpartum emotional complications such as postpartum depression. We agree to have Smith College's HSR review and approve the study.

Please contact me if you have any questions or concerns (413) 253 – 8990.

Best Regards,

Annette Cycon, LICSW
Founder Program Director MotherWoman
96 N Pleasant St
Amherst, MA 01004

Amherst, MA 01004
96 N Pleasant St
Founder Program Director MotherWoman
Annette Cycon, LICSW

FEB 09 2010

Best Regards

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circle@motherwoman.org
www.motherwoman.org

APPENDIX C

Initial Recruitment Letter, sent via email

Dear Mother,

Hi, my name is Leslie Lauf. I'm a student at the Smith College School for Social Work, conducting a study about MotherWoman's postpartum depression groups. I attended some sessions of the group in the Fall and have been impressed with the thoughtfulness of the participants and the rich format of the group. I may have met you there.

If you have attended six or more group meetings, I would like to **invite you to participate in a focus group**. As part of my graduate research, I would like to discover what aspects of the group you find most successful and what changes or improvements you might suggest. I have reviewed my plan with MotherWoman and think this would provide valuable information for them as well as help develop more good support groups for women experiencing postpartum stress.

On **Tuesday, June 1**, I would welcome your attendance at an approximately 45-60 minute focus group to discuss and provide anonymous feedback about the program. We will meet at Community Action, 56 Vernon St., Northampton, MA at 12:15 pm, directly following the group meeting. In an effort make your participation as convenient and comfortable as possible, lunch and childcare will be provided, using the same caregivers your children are used to at the site.

My research is learn your views about what aspects of the group are valued, and to collect suggestions and recommendations to improve the program. To make this an objective study, I will conduct these focus groups without facilitators present. Your participation is completely voluntary and your responses to the questions will be reported as group themes, not individual responses. Your name and identifying information will be kept anonymous in the reporting of the data. An informed consent form will be completed at the meeting of the focus group.

I hope you will come and lend your important perspective! Please let me know directly by **RSVPing to llauf@smith.edu**, or you can call me at **413-687-9903**. I'll be visiting the group this Tuesday, May 25th if you would like to speak to me further about this research. Please also contact me if you have any further questions while deciding.

Thank you!

Leslie Lauf

APPENDIX D

Informed Consent Form

Dear Participant,

My name is Leslie Lauf. I am a graduate student at the Smith College School for Social Work. I am conducting research that will become my thesis. I would like to hear about your participant in the postpartum support group run by MotherWoman. Specifically, I would like to hear your comments and discussion about particular aspects of the program and your suggestions for improvements.

If you agree to participate in this research study, I am requesting that you attend a focus group with 3-9 other women participants. It will require 45-60 minutes of your time and ask that you share your experience and opinions about several specific features. The session will be audiotaped and access will be granted only to myself and a research advisor. You have the right to discontinue participation in the study at any time, though our contributions will continue to be part of the data as it would be impossible to identify it and remove it from the group discussion.

Given the emotionally challenging state you are currently experiencing, you might find further discussion distressing. I have attached a list of referral sources for you if you feel that you need more support. I am hoping that this research will help determine what is useful about MotherWoman's support group model and what could be improved. Your participation in this research is a valuable contribution to our understanding of what helps new mothers who need support at this time. Participation in this study is complete voluntary. Food is being provided by donation.

Data collected will not be associated with your name, nor will the participants' names be revealed to anyone other than the researcher. No identifying information will appear in the transcriptions. Findings will be reported as group responses and any vignettes or quotes used in the report will be carefully disguised. In addition to myself, my research advisor at Smith College will have access to the data, but not your name or other identifying information.

As stated above, your participation is completely voluntary. Should you decide at any time that you do not wish to continue, you may withdraw from the study during the time I am collecting information. If you have any questions or concerns about your rights, please contact me directly (llauf@smith.edu) or call the Chair of the Smith College School for Social Work Human Subjects Review Committee at 413-545-7974.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Participant's signature

Date

Researcher's signature

Date

Referrals

Please contact the MotherWoman office directly for referrals:
Office address: 96 North Pleasant Street, Suite 202, Amherst, MA
Telephone: 413.253.8990
www.motherwoman.org

Area agencies providing counseling services:

ServiceNet Integrated Human Services
129 King Street, Northampton, MA
Telephone: 413.585.1300
www.servicenetinc.org

Clinical & Support Options
Outpatient Services
Greenfield: 413.774.1000
Northampton: 413.582.0471
www.csoinc.org

MassHealth Members can use this link to find providers in your network:
www.masspartnership.com/member/provsearch/provider.aspx

MotherWoman Group Principles

MotherWoman

- *designs groups with the intention of creating safety, consistency and clarity so that each woman can speak her truth.*
- *designs groups that are inclusive of all mothers regardless of race, class, age, sexual orientation, lifestyle and parenting choice.*
- *strives to create rare, treasured safe places of non-judgment and acceptance for all mothers.*

** We believe*

that speaking the truth about mothering is a revolutionary act, breaking silence, oppression and isolation for women. In our groups we support mothers in naming the deep challenges they are experiencing, knowing that there are few places where mothers can be truthful about the full spectrum of their experience.

** We know*

that mothering is both a blessing and a challenging experience. We explore the paradox, stress, pain and joy of the mothering experience. We do not sugarcoat it, but look for opportunities to find the gold, even in the darkest places.

** We have confidence*

that every woman has the wisdom within to navigate her life, when she feels heard, validated and honored for who she is, as she is.

** We believe*

that the state of a woman's motherhood is highly dependent on the state of her womanhood. Mothers cannot give from a depleted source. Therefore, our groups are designed to address the emotional, mental, physical and spiritual needs of the woman inside every mother, knowing that when she is well cared for, she will be a more effective parent.

APPENDIX F

MotherWoman Group Guidelines

1 - Confidentiality – We hold that everything said in group is sacred and cannot be shared outside of group to anyone. We even ask that members ask permission from the woman herself about what she shared in group before talking with her about it. Furthermore, we support every woman in declining from talking about her own story outside of group if she does not want to.

2 - We do not give advice or interrupt – MotherWoman is not an advice-giving forum. Advice is often heard as criticism and judgment. If a woman would like advice about something, she may ask for it outside of group. We ask each woman to show respect to the person speaking by not interrupting her. This is a precious gift to a mother. Please allow one woman to speak at a time, and allow women who have not participated a chance to speak before speaking a second time. **Crosstalk** – We encourage lively discussions about topics important to all of us, but we are committed to keeping these conversations safe for all. One way we do this is by asking women to speak from their own experience using “I” statements, rather than “you” statements. We do not encourage a group discussion about one woman’s story. If something is moving in a woman’s story, we ask that responses be made from an “I” statement. Rather than “It must be hard for you to be a single mother” try “I think it would be hard for me to be a single mother.”

3 - We hold each mother with respect, compassion and non-judgment. Every woman comes from a different place, may hold different values and parent her child or live her life differently. We believe that we are all doing the best we can with what we have and that we are all “winging it” on some level. Women and mothers can typically be very harsh on each other and ourselves, when what each of us really wants is to simply be witnessed with compassion.

4 - This is not a therapy group, and it should not replace therapy for a woman who needs it. One-on-one counseling can be very helpful at times of transition and stress. Motherhood often brings up personal issues that we cannot always adequately delve into in the course of the group. MotherWoman does not give advice on parenting or personal issues. We have a list of counselors/therapists that we are happy to share after group.

5 - Self-Care – We will facilitate a variety of experiences and there is always the option to “pass” or to re-design the experience to fit your own needs. Also, we support women in taking care of their needs in group, such as using the bathroom, taking a break, checking on their children, asking for a more comfortable chair, etc. Baby noises are welcome.